THOUSAND OAKS CITY COUNCIL

Supplemental Information

Agenda Related Items - Meeting of January 12, 2016
Supplemental Packet Date: January 12, 2016
2:30 P.M.

Supplemental Information:

Any agenda related public documents received and distributed to a majority of the City Council after the Agenda Packet is printed are included in Supplemental Packets. Supplemental Packets are produced as needed, typically a minimum of two—one available on the Thursday preceding the City Council meeting and the second on Tuesday at the meeting. The Thursday Supplemental Packet is available for public inspection in the City Clerk Department, 2100 E. Thousand Oaks Boulevard, during normal business hours (main location pursuant to the Brown Act, G.C. 54957.5(2) Both the Thursday and Tuesday Supplemental Packets are available for public review at the City Council meeting in the City Council Chambers, 2100 E. Thousand Oaks Boulevard.

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City of Thousand Oaks

Community Development Department
MEMORANDUM

2100 Thousand Oaks Boulevard • Thousand Oaks, CA 91362
Planning Division • Phone 805/449.2323 • Fax 805/449.2350 • www.toaks.org
Building Division • Phone 805/449.2500 • Fax 805/449.2575 • www.toaks.org

To: Scott Mitnick, City Manager

From: John C. Prescott, Community Development Director

Date: January 12, 2016

Subject: **Item 8A (Medical Marijuana Regulation) – Updated Table**

The attached table updates "Table 1: Status of Medical Marijuana Ordinances in Nearby Cities" which is Attachment #3 to the staff report (packet page 39) for this item. The table updates status as of January 12, 2016.

Submitted by:

John C. Prescott
Community Development Director

Prepared by:

Geoff M. Ware
Code Compliance Manager

CDD: 660-21/gmw/UpdatedTable1-12-16

2016 JAN 12 PM 1:58
CITY CLERK DEPARTMENT
CITY OF THOUSAND OAKS

TO COUNCIL 1-12-2016
AGENDA ITEM NO. 8.A.
MEETING DATE 1-12-2016

Table 1: Status of Medical Marijuana Ordinances in Nearby Cities

	City	Status
1	Agoura Hills	• Current ordinance bans all medical marijuana uses including cultivation, dispensaries (fixed and mobile), and delivery. No anticipated amendment.
2	Westlake Village	• Current ordinance bans all commercial medical marijuana uses including cultivation, dispensaries, and delivery. No anticipated amendment.
3	Simi Valley	• Current ordinance prohibits fixed or mobile dispensaries. • Amendment recommended by Planning Commission banning medical marijuana uses. • Exemption for cultivation by "qualified patient". • City Council introduced ordinance as recommended by Planning Commission, but to hold second public hearing on 1/25/16.
4	Moorpark	• Current ordinance prohibits marijuana dispensaries in commercial/industrial zones. • Planning Commission recommendation to City Council completed, to refine ordinance to include additional prohibition in other zones for cultivation and adding prohibitions for delivery. Exemption for cultivation by "qualified patient" on property being resided upon. • City Council introduced ordinance prohibiting cultivation except for patient, excluding deliveries (to be dealt with in separate ordinance).
5	Camarillo	• Current ordinance prohibits fixed and mobile dispensaries, including mobile delivery (exception for a primary caregiver delivering to qualified patient). • Planning Commission recommendation to City Council completed, adding prohibitions for all cultivation city-wide. • Public hearing scheduled for 1/13/16.
6	Oxnard	• Currently adopted uncodified ordinance prohibiting "sale, supply or provision" of marijuana within the city. • Amendment scheduled for CC on 1/12/16. Staff recommendation for prohibition on dispensaries (fixed or mobile), delivery, and any cultivation.
7	Ventura	• Current ordinance prohibits medical marijuana distribution facilities (dispensaries and cultivation) city-wide. • Currently exempts qualified patients and primary caregivers from cultivation per State standards.
8	County of Ventura	• Staff recommendation to Board of Supervisors to have ordinance drafted prohibiting all commercial cannabis activity regulated by MMRSA. Ordinance would exempt cultivation by qualified patient and primary caregiver. Pending Planning Commission hearing.

Rev 1/12/16

Hello, my name is Joe Kyle. I have been a resident of Thousand Oaks my entire life. Fellow patients and I will be attending the public hearing, on January 12th, about the ordinance the planning commission has put forth. The ordinance to ban commercial cultivation, dispensaries, and delivery services.

Here are some articles from the Americans for Safe Access, that I have read through and highlighted what I feel to be the most important topics. I also highly recommend the Blue Ribbon Commission, if you would like to dig deeper. Lt Governor Gavin Newson help write it. It is the states idea of how medical cannabis should be regulated. He believes it should be modeled after the beer and wine industry.

I am in connection with many patients of Thousand Oaks and would like to offer a helping hand in any question, comments, or concerns anyone may have through this litigation process. I feel that we can all work together as medical cannabis patients, lawmakers, law enforcement, and neighboring business's. To draft an ordinance that we can all agree with. The March 1st deadline is no longer an issue. On Tuesday, January 5th, Assembly Bill 21 was introduced. Its purpose was to remove March 1st, 2016, as the deadline. I had brought you a letter from Assemblyman Jim Wood, before Christmas vacation had commenced. If anyone has any questions. Feel free to call me at (805)807-5303. I am also available by email at joejek3@aol.com. Thank you very much for your time. I hope that we can all build a very bright future together and add to the safety of this great city.

Sincerely,

Joe Kyle

Joe Kyle

CITY OF THOUSAND OAKS
2016 JAN -7 P 4:14
CITY MANAGER'S OFFICE

CITY OF THOUSAND OAKS
CITY CLERK DEPARTMENT
2016 JAN -7 PM 5:06

TO COUNCIL 1-12-2016
AGENDA ITEM NO. 8.A.
MEETING DATE 1-12-2016

AmericansFor SafeAccess
Advancing Legal Medical Marijuana Therapeutics and Research

TO: City Councils and County Boards of Supervisors in California
DATE: December 21, 2015
RE: Local Government and the Medical Marijuana Regulations and Safety Act (MMRSA)

Key Points

1. The Medical Marijuana Regulation and Safety Act (MMRSA) gives cities and counties a clear indication of what is legal under state law and empowers them to license and regulate commercial medical cannabis activity.
2. While implementation of the MMRSA will take some time, cities and counties can begin the process of necessary local licensing now.
3. Some provisions of the MMRSA affect cities and counties directly.
4. Local bans on personal patient cultivation and commercial medical cannabis cultivation are unnecessary and harmful.

Background

California voters legalized medical cannabis (marijuana) when they approved the Compassionate Use Act (Proposition 215) in 1996. Codified as Health and Safety Code Section 11362.5, the voter initiative calls on lawmakers "to implement a plan to provide for the safe and affordable distribution" of medical cannabis.

Cities and counties have adopted a patchwork of local regulations related to medical cannabis since 1996. Until recently, however, state lawmakers were reluctant to adopt statewide licensing and regulations for medical cannabis activity. In that legal vacuum, some cities and counties began to experiment with regulations for local access programs to meet the needs of legal patients.

Most of the early local ordinances regulating medical cannabis focused on safety, preventing diversion of medicine, and land use issues around local access points (often called *dispensaries*). Local lawmakers did not address issues regarding cultivation, manufacturing, or laboratory testing in these early ordinances. Many cities and counties

remained ambivalent about licensing or regulating medical cannabis activity in the absence of clear guidance from the state.

Governor Brown signed the Medical Marijuana Regulation and Safety Act (MMRSA) on October 9, 2015, finally bringing some clarity under state law as to the rights and responsibilities of businesses, organizations, and individuals in the field of medical cannabis. The adoption of the MMRSA presents a unique opportunity for cities and counties to revisit their policies regarding commercial medical cannabis activity and bring local ordinances into harmony with this groundbreaking legislation.

Americans for Safe Access (ASA), the nation's leading medical cannabis patient advocacy organization, works in partnership with elected officials at all levels of government to overcome barriers to safe and legal access to medical cannabis for therapeutic use and research. We would like to help cities and counties in California adopt local licensing laws that protect legal patients, reduce crime and complaints, and assist law enforcement in identifying legal medical cannabis businesses and organizations.

The Medical Marijuana Regulation and Safety Act (MMRSA)

Three separate bills comprise the MMRSA – AB 243, AB 266, and SB 643. Each deals with different aspects of licensing and regulating commercial medical cannabis cultivation, manufacturing, distribution, transportation, sales, and testing. The MMRSA is a milestone in California medical cannabis law, because it will create the first legal state licensing for businesses and organizations that are specifically authorized to provide medical cannabis (cultivation, manufacturing, dispensing) and industry support services (testing, transportation) in California.

The MMRSA becomes effective January 1, 2016. The Act creates the Bureau of Medical Marijuana Regulation (BMMR) within the Department of Consumer Affairs to write regulations and oversee licensing. The new law also puts the Department of Food and Agriculture in charge of writing regulations for medical cannabis cultivation. The Department of Health will write regulations for edible preparations of cannabis. The Department Fish and Wildlife and the State Water Board are charged with writing rules for commercial cultivation that protect water quality.

It may take months for the new BMMR to organize and begin operating as a regulatory agency. The other state agencies will also need some lead-time to get started on this unprecedented work. While the MMRSA is effective on January 1, 2016, the

requirement that medical cannabis businesses and organizations obtain both a state and local license to operate does not become effective until January 1, 2018. For a detailed look at the timeline and deadlines in the MMRSA, see Table 1 at the end of this memorandum.

The MMRSA creates seventeen different state medical cannabis licenses. The Act also contains complicated restrictions designed to prevent vertical integration in the medical cannabis industry. In most circumstances, licensees are limited to holding licenses in two categories. (See Table 2 for details about different state licenses.)

It is important to note that: (1) cities and counties do not have to duplicate the state license types in local ordinances (see more below), and (2) medical cannabis businesses or organizations operating in cities and counties that adopted ordinances requiring or allowing vertical integration ("closed-loop" system) before July 1, 2015, are generally exempt from the MMRSA's restrictions on holding more than two types of licenses.

The MMRSA contains numerous other provisions, some of which affect local government. See Table 3 for a concise summary of the Act's provisions prepared by Dale Gieringer, Ph.D., from CA NORML. The full text of each bill, including the Legislative Counsel's Digest, is available on the LegInfo website at http://leginfo.legislature.ca.gov.

The MMRSA and Local Government

The MMRSA gives local government broad latitude in regulating medical cannabis activity. In fact, preserving local authority was a top priority for the authors of the bills that comprise the MMRSA.

- Authorized medical cannabis license applicants in cities and counties with existing local ordinances that require or allow for "closed loop" patients' cooperatives and collectives, in accordance with California Health and Safety Code Section 11362.775, may continue to operate under the local ordinance until January 1, 2026 (AB 266, Section 19328). That means no disruption for existing program authorized under local law for ten years.
- Applicants for state medical cannabis licenses must also obtain a license, permit, or approval from the city or county in which they are operating or propose to operate [AB 266, Section 1932(a) and AB 243, Section 1362.777(b)].
- Existing medical cannabis business and organizations operating with local approval may continue to operate until their state license is approved or denied.

- If a city or county does not address commercial medical cannabis cultivation in an ordinance before March 1, 2016, state regulators will become the sole licensing authority. See below for more details on this provision [AB 243, Section 11362.777(c)(4)].
- **Assembly Member Jim Wood (D-Santa Rosa), the author of AB 243, stated in an open letter to local lawmakers in December of 2015, that the March 1, 2015, deadline for adopting local ordinances was the result of "an inadvertent drafting error." The Assembly Member noted this error in the Assembly Journal, the official record of the Assembly, and is already engaged in a bipartisan effort to remove the deadline. The Assembly Member concludes his letter to local lawmakers by saying, "I am confident that my colleagues and I will eliminate the March 1st deadline before it becomes a realistic problem as opposed to a theoretical concern for lawmakers." The letter is attached, following the tables, at the end of the memorandum.**

Bans on Personal and Commercial Medical Cannabis Cultivation

Some cities and counties have banned the personal and commercial cultivation of medical cannabis since the adoption of the MMRSA. This is an unnecessary step that is harmful to patients and may deprive the cities and counties of the proven benefits of regulation. ASA urges local lawmakers to remember that cannabis is a legitimate medicine that can and should be properly licensed and regulated under state and local law. It is not a vice or a nuisance. Furthermore, ASA urges local lawmakers to consider the jurisdictions posture towards personal and commercial cultivation as *separate* issues.

<u>There is a legitimate need for local access to medical cannabis.</u>

1. **Many Californians already use medical cannabis, and most report relief from a serious medical condition.** Research shows that more than 1.4 million Californians have used medical cannabis already, and 92% of those report significant relief from a serious medical condition. The most commonly treated conditions include chronic pain, arthritis, migraines, and cancer – conditions for which conventional treatments are often unavailable or ineffective. Furthermore, research shows that cannabis is used by a population that is diverse in age, race, gender, and other factors ["Prevalence of medical marijuana use in California, 2012," *Drug and Alcohol Review* (2014)]. Given that so many Californians are already using medical cannabis to treat serious conditions, it is

certain that legal patients who live, work, and shop in your community have a need for safe and legal access already.

2. **Mounting scientific evidence confirms that cannabis and cannabis products are safe and effective.**
    a. The University of California established the Center for Medical Cannabis Research (CMCR) in 2001 to conduct scientific studies to ascertain the general medical safety and efficacy of cannabis products and examine alternative forms of cannabis administration. In 2010, the CMCR issued a report on the fourteen clinical studies it has conducted, most of which were FDA-approved, double-blind, placebo-controlled clinical studies that have demonstrated that cannabis can control pain, in some cases better than the available alternatives (Grant I, et al. 2010. *Report to the Legislature and Governor of the State of California*. Center for Medicinal Cannabis Research).
    b. The Institute of Medicine released the largest review of research on medical cannabis in its 1999 report *Marijuana and Medicine: Assessing the Science Base*. The report found medical benefits for treating cancer and other conditions, noted that cannabis was uniquely effective for some patients, and called for more research. Read the report at http://www.nap.edu/read/6376/chapter/1
    c. See http://www.safeaccessnow.org/research for additional information about clinical research related to medical cannabis and specific conditions.

Recommendation: License and regulate medical cannabis at the local level like other legitimate medicines. Lawmakers must remember that it is inappropriate to regulate legitimate medicines as they do vices, including alcohol and tobacco.

Bans on individual patient and primary caregiver cultivation.

1. **Bans on individual patient and primary caregiver cultivation are harmful to patients.** Many patients who legally use medical cannabis cultivate their own medicine at home or in another safe and discrete place. Some designate a Primary Caregiver to help with cultivation, in accordance with California Health and Safety Code 11362.7. Personal, non-commercial cultivation of cannabis can be less expensive for patients than purchasing it. It may also be the only way to consistently obtain a specific variety of medicine that is useful for treating an individual patient's condition.

2. **Bans push legal patients into the illicit market.** Patients who cannot grow their own medicine may turn to the illicit market for relief, especially in areas where commercial medical cannabis cultivation and dispensing are not permitted. Patients face unnecessary legal, personal, and safety risks in the illicit market. Eliminating those risks for patients was a primary motive for adopting medical cannabis laws in California.
3. **Bans on personal cultivation are not required under the MMRSA.** The new state law does not forbid individual patients and their designated primary caregivers from cultivating medical cannabis for the personal use of the patient. In fact, the MMRSA specifically exempts individual patients and primary caregivers from licensing and regulation requirements. Some cities and counties have banned commercial medical cannabis cultivation in hopes of maintaining control over licensing cultivation under the MMRSA, as discussed in greater detail below. However, there is no requirement or deadline for local government to ban, license, or regulate the personal cultivation of patients and caregivers. *The issues of commercial and personal medical cannabis cultivation can and should be handled separately.*
4. **Personal cultivation is not usually associated with criminal or nuisance activity.** Some cities and counties have banned commercial cultivation and dispensing of medical cannabis based on an unfounded belief that this activity increases crime (see more below). However, it is important to remember that there is no evidence that the personal cultivation of legal medical cannabis is associated with increased criminal nuisance activity.

Recommendation: Allow medical cannabis patients and primary caregivers to cultivate medicine for the personal use of the patient. ASA's model ordinance for regulating commercial medical cannabis cultivation exempts patients and primary caregivers from local licensing regulation and does not interfere with their right to cultivate for personal use under the Compassionate Use Act of 1996 (Proposition 215).

Bans on commercial medical cannabis cultivation.

1. Banning commercial cultivation leaves the majority of legal patients without safe and legal access. Most legal patients rely on dispensaries for safe and legal access to medical cannabis. The MMRSA anticipates that licensed commercial cultivators will supply licensed dispensaries with medical cannabis. However, cultivators and dispensaries must have a local license,

permit, or approval to operate. That means local bans on commercial cultivation could choke off access to dispensaries servicing legal patients.

2. Cities and counties are empowered to regulate commercial medical cannabis cultivation under the MMRSA. One of the goals of the new legislation is to give the green light for local licensing and regulation. The MMRSA should give clear legal guidance and approval to local lawmakers who were previously ambivalent about local licensing. Cities and counties can now be certain that licensed medical cannabis businesses and organizations are operating within the bounds of state law.
3. There is no urgency to enact an ordinances licensing commercial medical cannabis cultivation before the March 1, 2016. As noted above, the inclusion of a deadline for adopting local cultivation regulations was included in AB 243 inadvertently. The current language in Section 11362.777 (c)(4) in AB 243, which includes the drafting error identified by Assembly Member Wood in the Assembly Journal, gives the BMMR authority to license medical cannabis cultivation in cities and counties that have not addressed commercial cultivation before March 1, 2016. While the delaine is likely to be removed from AB 243, cities and counties can adopt simple business licensing ordinances like ASA's model ordinance for commercial medical cannabis activity before March 1, 2016.
4. Cities and counties can use existing business license and zoning laws to license commercial medical cannabis activity. Most jurisdictions already have adequate business license, zoning, and other land use laws that can be used for medical cannabis. There is no need to reinvent the wheel.
5. Cities and counties do not have to develop complex regulatory schemes for commercial medical cannabis licensing. The BMMR will be doing that. The BMMR and other state agencies will begin writing comprehensive regulations in January of 2018. All state laws and regulations will be applicable to medical cannabis businesses and organizations licensed, permitted, or approved under local laws.
6. Unlike illicit cultivation, licensed and regulated commercial medical cannabis cultivation can be easily monitored and policed. Licensed commercial medical cannabis cultivators operate in the open. That makes the job of regulators and law enforcement much easier. Cities and counties can expect greater transparency from licensed cultivators in areas like security, zoning, and environmental impacts.
7. Licensed commercial medical cannabis cultivation can create jobs, generate tax revenue, and have other economic benefits for the community.

Researchers from The ArcView Group, a cannabis industry investment and research firm based in Oakland, California, found that the U.S. market for legal cannabis grew 74 percent in 2014 to $2.7 billion, up from $1.5 billion in 2013. According to the *Washington Post*, the cannabis industry will be worth $35 billion by 2020 – bigger than the National Football League and on par with the newspaper industry. That means jobs and tax revenue for local governments that take advantage of the new state licensing to authorize legal medical cannabis organizations and businesses.

Recommendation: License and regulate commercial medical cannabis cultivation instead of banning it. ASA's model ordinance for commercial medical cannabis cultivation is a simple way to preserve local authority and secure the benefits of sensible licensing and regulation for patients, the community at large, and law enforcement.

Conclusion

ASA is committed to helping cities and counties find the best possible solution for licensing commercial medical cannabis activity, while protecting the interests and welfare of legal patients. We strongly believe that cities and counties should move forward with licensing, permitting, or approving medical cannabis activity pursuant to the MMRSA. Banning personal patient cultivation or commercial medical cannabis cultivation is harmful to legitimate patients. It may also deprive communities of the proven benefits of sensible regulation: reduced crime, fewer complaints, greater clarity for all stake holders (especially law enforcement), tax revenue, and more.

Please contact ASA California Director Don Duncan at don@safeaccessnow.org or (916) 449-3975 for more information.

List of Tables:

Related Documents from ASA:

Sample Ordinance Licensing Commercial Medical Cannabis Cultivation
http://www.safeaccessnow.org/ca_local_cultivation_ordinance

Report: Where Will Medical Marijuana Patients Obtain Their Medicine?
https://american-safe-access.s3.amazonaws.com/documents/dispensary_report_2015.pdf

Additional Resources from ASA:
http://www.safeaccessnow.org/resources_for_local_organizers

Table 1 – Timeline and Deadlines in MMRSA

7/1/2015	Date by which those claiming vertical integration had to be operating a vertically integrated business. (AB 266 Section 19328 (c1))
1/1/2016	Date on which AB 266, AB 243 and SB 643 will take effect. (See the end of the legislative summaries in all three bills)
1/1/2016	Date by which cannabis businesses must be operating to be eligible for priority licensing. "In issuing licenses, the licensing authority shall prioritize any facility or entity that can demonstrate to the authority's satisfaction that it was in operation and in good standing with the local jurisdiction by January 1, 2016." [AB 266 Section 19321 (c)]
3/1/2016	Date by which cultivation must be regulated by a locality: "If a city, county, or city and county does not have land use regulations or ordinances regulating or prohibiting the cultivation of marijuana, either expressly or otherwise under principles of permissive zoning, or chooses not to administer a conditional permit under principles of permissive zoning, or chooses not to administer a conditional permit program pursuant to this section, then commencing March 1, 2016, the division shall be the sole licensing authority for medical marijuana cultivation applicants in that city, county, or city and county." (AB 243 Section 19362.777(c)(4)) **NOTE: According to the author, this provision was included as a result of a drafting error and will be removed.**
1/1/2017	By January 1, 2017, the Division of Occupational Safety and Health shall convene an advisory committee to evaluate whether there is a need to develop industry-specific regulations related to the activities of facilities issued a licensee. (AB 266 Labor Code Amendment Sec. 7 147.5)
7/1/2017	By July 1, 2017, the advisory committee shall present to the board its findings and recommendations for consideration by the board. (AB 266 Labor Code Amendment Sec. 7 147.5)
7/1/2017	By July 1, 2017, the board shall render a decision regarding the adoption of industry-specific regulations pursuant to this section. (AB 266 Labor Code Amendment Sec. 7 147.5)
1/1/2018	"A facility or entity that is operating in compliance with local zoning ordinances and other state and local requirements on or before January 1, 2018, may continue its operations until its application for licensure is approved or denied pursuant to this chapter." (AB 266 Section 19321 (c))
1/1/2020	Not later than January 1, 2020, the Department of Food and Agriculture in conjunction with the Bureau, shall make available a certified organic designation and organic certification program for medical marijuana, if permitted under federal law and the National Organic Program. [SB 643 Section 19332.5(a)]
1/1/2022	Date by which the loan of up to $10,000,000 from the general fund to establish the Medical Marijuana Regulation and Safety Act has to be repaid. If the fees collected by that time don't repay the loan, they will begin using funds that come from imposing penalties to repay the loan. [AB 243 Section 19351 (b)(1)]

3/1/2023	Beginning on March 1, 2023, and on or before March 1 of each following year, each licensing authority shall prepare and submit to the Legislature an annual report on the authority's activities and post the report on the authority's Internet Web Site. (AB 266 Section 19353)
1/1/2026	The date Type 10A Paragraph on licensing becomes inoperative "A Type 10A licensee may apply for a Type 6 or 7 state license and hold a 1, 1A, 1B, 2, 2A, 2B, 3, 3A, 3B, 4 or combination thereof if, under the 1, 1A, 1B, 2, 2A, 2B, 3, 3A, 3B, 4 or combination of licenses thereof, no more than four acres of total canopy size of cultivation by the licensee is occurring throughout the state during the period that the respective licenses are valid… This paragraph shall become inoperative on January 1, 2026." [(AB 266 Section 19328 (a) (9)]
1/1/2026	Date vertical integration section of AB 266 is repealed. [AB 266 Section 19328 (d)]

National Office
1806 Vernon St. NW, Suite 300, Washington DC 20009
PHONE: 202.857.4272 FAX: 202.857.4273

California Office
770 L Street, Suite 950, Sacramento, CA 95814
PHONE: 916.449.3975

General Information
WEB: www.AmericansForSafeAccess.org
TOLLFREE: 888-929-4367

Table 2 – Types of State Licenses Under the MMRSA

Type 1	Cultivation; Specialty outdoor. Up to 5,000 square ft of canopy, or up to 50 noncontiguous plants.
Type 1A	Cultivation; Specialty indoor. Up to 5000 sq ft.
Type 1B	Cultivation; Specialty mixed-light. Using exclusively artificial lighting.
Type 2	Cultivation; Outdoor. Up to 5000 sq ft, using a combination of artificial and natural lighting.
Type 2A	Cultivation; Indoor. 5001 -10,000 sq ft.
Type 2B	Cultivation; Mixed-light. 5001 -10,000 sq ft.
Type 3	Cultivation; Outdoor. 10,001 sq ft - 1 Acre.
Type 3A	Cultivation; Indoor.. 10,001 - 22,000 sq ft.
Type 3B	Cultivation; Mixed-light. 10,001 - 22,000 sq ft.
Type 4	Cultivation; Nursery.
Type 6	Manufacturer 1 for products not using volatile solvents.
Type 7	Manufacturer 2 for products using volatile solvents.
Type 8	Testing.
Type 10	Dispensary; General.
Type 10A	Dispensary; No more than three retail sites.
Type 11	Distribution.
Type 12	Transporter.

Table 3 – Summary of the Provisions of the MMRSA

CULTIVATION SIZE LIMITATIONS	The maximum allowable size is 1 acre (43,560 sq ft) outdoors (Type 3) or 22,000 sq ft indoors (Type 3A and 3B licenses). The DFA is directed to limit the number of Type 3, 3A and 3B licenses. [AB 243, 19332(g)].
VERTICAL INTEGRATION	There are complicated restrictions to prevent vertical integration (AB 266, 19328). In general, licensees can only hold licenses in up to two separate categories. Small cultivation licensee Types 1-2 may hold manufacturing or Type 10A retail licenses (limited to three dispensaries). It appears that Types 3-4 licensees can't apply for manufacturing licenses at all. However, Type 10A licensees can apply for both manufacturing and cultivation licenses, provided their total cultivation area doesn't exceed 4 acres. Also, facilities in jurisdictions that require or permit cultivation, manufacture, and distribution to be integrated as of July 1, 2015, may continue to operate that way until Jan 1, 2026.
DISTRIBUTORS REQUIRED	Type 11 distributors are a new kind of entity that has been created to regulate the flow of products. ALL cultivation and manufacturing licensees are required to send their products to a Type 11 licensee for quality insurance and inspection before passing them to the next stage of manufacturing or retailing. The Type 11 licensee in turn submits the product to a Type 8 laboratory for batch testing and certification. Afterwards, the sample returns to the Type 11 distributor for final inspection and execution of the contract between the cultivator and manufacturer or manufacturer and retailer. The Type 11 distributor charges a fee that covers the testing plus any applicable taxes (the Act doesn't impose any new taxes, but anticipates that could happen in the near future) (AB 266, 19326) Type 11 distributors and Type 8 testing facilities cannot hold any other kind of licenses (however, licensees may have their own labs for in-house testing).
LOCAL PERMITS REQUIRE	No person shall engage in commercial activity without BOTH a state license and a license, permit, or other authorization from their local government. (AB 266, 19320(a); AB 243, 11362.777 (b)).
LAWFUL ACTS	Actions by licensees that are permitted by both a state license and local government are lawful, and the licensee is protected from arrest, prosecution, or other legal sanctions (AB 266, 19317).
GRANDFATHERING	Facilities already operating in compliance with local ordinances and other laws on or before Jan 1, 2018 may continue to operate until such time as their license is approved or denied. [AB 266, 19321(c)]. Facilities in operation before Jan 1, 2016, shall receive priority. Los Angeles may in any case continue to prosecute violations of Measure D.

APPLICANT QUALIFICATIONS (SB 643, 19322):	Applicants must provide proof of local approval and evidence of legal right to occupy any proposed location. Applicants shall submit fingerprints for DOJ background check. Cultivation licensees must declare themselves "agricultural employers" as defined by Alatore-Zenovich-Dunlap-Berman Agricultural Labor Relations Act. A licensing authority MAY deny an application if the applicant has been convicted of an offense substantially related to qualifications, including ANY felony controlled substance offense, violent or serious felonies, or felonies involving fraud, deceit or embezzlement, or any sanctions by a local licensing authority in the past 3 years [SB 643, 19323(a)(5)].
FOR-PROFIT ENTITIES	Are implicitly allowed under the qualifications established above. These were previously "not authorized" under SB 420, but the new licensing provisions extend to individuals, partnerships, corporations, business trusts, etc. [under the definition of "person" in AB266, 19300.5 (a)]. Likewise, applicants no longer need be patients.
CULTIVATION LICENSING	The DFA shall establish a medical cannabis cultivation program. All cultivation is subject to local land use regulations and permits. In cities and counties without cultivation regulations of their own, the state shall be the sole licensing authority as of March 1, 2016 [AB 243, 11362.777 (c)(4)]. **NOTE: According to the author, this provision was included as a result of a drafting error and will be removed.**
TRACK & TRACE PROGAM	The DFA shall implement a unique identification program for all marijuana plants at a cultivation site, to be attached at the base of each plant. The information shall be incorporated into a "track and trace" program for each product and transaction [SB 643, 19335 and AB 243, 11362.777 (e)]. Cultivation in violation of these provisions is subject to civil penalties up to twice the amount of the license fee, plus applicable criminal penalties. Fines enacted daily for each violation (SB 243, 19360).
PATIENT EXEMPTION	Qualified patients are exempt from the state permit program if cultivating less than 100 square feet for personal medical use. Primary caregivers with five or fewer patients are allowed up to 500 square feet [AB 243, 11362.777(g) and SB 643, 19319]. Exemption under this section does not prevent a local government from further restricting or banning the cultivation, provision, etc. of medical cannabis by individual patients or caregivers in its jurisdiction (AB 243).
DELIVERIES	Cannabis may be delivered to qualified patients only by dispensaries and only in cities or counties where not prohibited by local ordinance. All deliveries are to be documented. No locality can bar transport of delivered products through its territory. Local county may tax deliveries. (AB 266, 19340). {In a separate section [19334 (a) 4] it is confusingly stated that dispensers who have no more than three dispensaries (Type 10A) shall be allowed to deliver "where expressly authorized by local ordinance." It's unclear what conditions if any apply to other, Type 10 licensed dispensers.}
MANUFACTURERS	Manufacturers are to be licensed by DPH. The DPH shall limit the number of Type 7 licenses that produce products using volatile solvents.

TESTING (AB 266, 19341-6)	The DPH shall ensure that all cannabis is tested prior to delivery to dispensaries or other businesses, and specify how often such testing shall be conducted. [Confusingly, 19346(c) says the costs of testing are to be paid by cultivators, whereas 19326(c) (3) states that distributors shall charge for the costs of testing; since distributors serve manufacturers as well as cultivators, it doesn't make sense that testing costs for the former should be charged to the latter.] Licensees shall use standard methods established by International Organization for Standardization approved by an accrediting body that is a signatory to the International Laboratory Accreditation Cooperation Mutual Recognition Arrangement (AB 266, 19342). Licensees shall test for cannabinoids, contaminants, microbiological impurities, and other compounds spelled out in Section 19344. Licensees may conduct tests for individual qualified patients, but not certify products for resale or transfer to other licensees.
SCHOOL ZONES	Cultivation and dispensary facilities must be at least 600 ft from schools (with grandfathered exceptions specified in HSC 11362.768). [SB 643, 19322 (a) 4]
TRANSPORTATION	Only licensed transporters can transport cannabis or cannabis products between licensees [AB 266, 19326(a)]. The bill doesn't specify whether cultivators, manufacturers, or retailers can also have transport licenses, but 19328 (a) states they can generally have at most two separate kinds of licenses. Licensed transporters shall transmit an electronic shipping manifest to the state and carry a physical copy with each shipment (SB643, 19337).
LABOR PEACE AGREEMENTS	Labor peace agreements are required of all applicants with 20 employees or more (SB 643, 19322 a (6))
PACKAGING	Products shall be labeled in tamper-evident packages with warning statements and information specified in Section 19347.
PRIVACY	Identifying names of patients, caregivers, and medical conditions shall be kept confidential. (AB 266, 19355)
SB 420 COLLECTIVE DEFENSE SUNSET	The provision in SB 420 affording legal protection to patient collectives and cooperatives, HSC 11362.775, shall sunset one year after the Bureau posts a notice on its website that licenses have commenced being issued. After that date, all cannabis collectives will have to be licensed, except for individual patient and caregiver gardens serving no more than five patients.
PHYSICIAN RECOMMENDATIONS (SB 643):	There are several new provisions clarifying the duties of medical cannabis physicians; however, they don't substantially affect or impair patients' current access to medical recommendations.
	• The Med Board's enforcement priorities are amended to include "Repeated acts of clearly excessive recommending of cannabis for medical purposes, or repeated acts of recommending without a good faith prior exam." (SB 643, 2220.05). This is
	identical to existing language regarding controlled substances, which has generally been assumed to apply to MMJ heretofore.
	• It is unlawful for physicians who recommend to accept, solicit, or offer remuneration to or from a licensed facility in which they or a family member have a financial interest.
	• The Med Board shall consult with the California Center for Medicinal Cannabis Research in developing medical guidelines for MJ recs.

	• The recommending person shall be the patient's "attending physician" as defined in HSC 11362.7(a). Contrary to popular misconception, this in nothing new and in no way limits patients to their primary care physician. It merely restates current language in SB 420.
	• Physician ads must include a warning notice that MMJ is still a federal Schedule I substance.
PESTICIDE STANDARDS	Pesticide standards shall be promulgated by DFA and the Dept. of Pesticide Regulation (SB643, 19332).
ORGANIC CERTIFICATION	Organic certification will be made available by DFA by Jan 1, 2020, federal law permitting. [SB643, 19332.5(a)]
APPELLATIONS OF ORIGIN	The bureau MAY establish appellations of origin for cannabis grown in California. No product may be marketed as coming from a county where it was not grown. [SB643, 19332.5(b-d)]
FEES and FUNDING	Each licensing authority shall establish a scale of application, licensing and renewal fees, based upon the cost of enforcement. Fees shall be scaled dependent on the size of the business [AB 243, 19350 (c)]. A Medical Marijuana Regulation and Safety Act Fund is established in the state treasury to receive fees and penalties assessed under the act. $10 million is allocated to DCA to begin operations, with the possibility of an additional operating loan of $10 million from the General Fund (AB 243, 19352). The Bureau shall use the fund for a grant program to assist state and local agencies in enforcement and remediation of environmental impacts from cultivation. (AB 243, 19351)
COUNTY TAXATION	Counties may levy a tax on the cultivating, dispensing, producing, processing, distributing, etc., of medical cannabis subject to standard voter approval requirements. (Many cities already exercise this authority, but the authority of counties to do so has been unclear heretofore). (SB 643, 19348)

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JIM WOOD
ASSEMBLYMEMBER, SECOND DISTRICT

STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0002
(916) 319-2002
FAX (916) 319-2102
DISTRICT OFFICES
50 D STREET, SUITE 450
SANTA ROSA, CA 95404
(707) 576-2526
FAX (707) 576-2297
710 E STREET, SUITE 150
EUREKA, CA 95501
(707) 445-7014
FAX (707) 445-6607
200 S SCHOOL STREET, SUITE D
UKIAH, CA 95482
(707) 462-5770
FAX (707) 463-5773

The Marijuana Regulation and Safety Act's March 1st Deadline

An open letter to County and City Government Officials:

Like many of my colleagues, I began my public service career at the local level where decisions made in Sacramento often have a profound impact on the decisions we make in our communities. Over the past several weeks, I have learned that cities and counties are scrambling to put regulations regarding medical marijuana in place ahead of a March 1st deadline that was inadvertently included in AB243 of the Medical Marijuana Regulation and Safety Act (MMRSA). As a former local elected I understand this reaction. However, I am writing this letter to clarify some of the confusion that has resulted from the inclusion of the March 1st deadline in the MMRSA.

The MMRSA will bring a multi-billion dollar industry that has grown up largely in the shadows into the light. Ultimately, the goal is to provide Californians with the legal, consumer, and environmental protections we have come to expect from any other industry.

During the scramble at the end of the legislative session this year, an inadvertent drafting error placed a deadline on local jurisdictions, requiring them to adopt their own land use regulations for medical cannabis cultivation by March 1, 2016, or turn that responsibility over to the state. As soon as I was aware of the error I published a letter in the Assembly Journal, the official record of the Assembly, declaring my intention to pass urgency legislation as soon as the legislature reconvenes in January. The compromise agreement with the Governor's office did not include the March 1st deadline and this urgency legislation will ensure that the MMRSA's legislative intent is not altered. I have already amended one of my bills with language that will strike the deadline and maintain a local jurisdiction's ability to create their own regulations. As an urgency measure, the law will go into effect as soon as it is signed by the Governor.

My intent to remove the deadline has bi-partisan and stakeholder support. The Governor's office is prepared to partner with my office to ensure local control on this issue. I appreciate the Governor's acknowledgement of this drafting error and his office's willingness to work with me to quickly resolve the problem. Even if my urgency measure is not signed until after March 1st,

the Bureau of Medical Marijuana Regulation (BMMR), the entity responsible for developing the State's regulations, currently exists on paper only. It will be many months before the Bureau has the capacity to develop and enforce statewide regulations. Additionally we have received legal feedback confirming that once my urgency measure is in effect jurisdictions will retain the local control they need.

I am confident that my colleagues and I will eliminate the March 1st deadline before it becomes a realistic problem as opposed to a theoretical concern for local lawmakers.

Respectfully,

JIM WOOD
ASSEMBLYMEMBER, 2ND DISTRICT

National Office
1806 Vernon St. NW, Suite 300, Washington DC 20009
PHONE: 202.857.4272 FAX: 202.857.4273

California Office
770 L Street, Suite 950, Sacramento, CA 95814
PHONE: 916.449.3975

General Information
WEB: www.AmericansForSafeAccess.org
TOLLFREE: 888-929-4367

This simple draft ordinance authorizes commercial medical cannabis cultivation using the existing city or county business license process and sets some basic security standards for indoor and outdoor cultivation. The ordinance protects staff, operators, and landlords at licensed grows; allows cultivation in commercial and agricultural zones; and exempts individual patients and caregivers from licensing requirements.

____ Purposes.

The purposes and intents of this Chapter are to:

a) Regulate commercial medical cannabis cultivation in a manner that is consistent with State law and which promotes the health, safety, and general welfare of the residents and businesses in <*name of local jurisdiction*>;
b) Provide clear guidance to law enforcement, regulators, license holders, and the community at large as to what is legally permitted in <*name of local jurisdiction*> in relation to commercial medical cannabis cultivation; and
c) Protect the rights and welfare of Qualified Patients or their designated Primary Caregivers who cultivate medical cannabis for the personal medical use of the Qualified Patient in accordance with the Compassionate Use Act and the Medical Marijuana Program Act.

Nothing in this Chapter shall be construed to allow:

a) Persons to engage in conduct that endangers others or causes a public nuisance;
b) The use or diversion of marijuana for nonmedical purposes; or
c) Any activity relating to the cultivation, distribution or consumption of marijuana that is otherwise illegal under State law.

____ Findings.

a) There is a legitimate need for medical cannabis in California. A study published in 2014 shows that 1.4 million Californians have used medical cannabis and an overwhelming majority of those users (92%) believe cannabis helped treat the symptoms of a serious medical condition ("Prevalence of medical marijuana use in California, 2012", *Drug and Alcohol Review* (2014), DOI 10.111/dar. 12207).
b) According to that research, more than 30% used medical cannabis to treat chronic pain, 11% used it for arthritis, 8% for migraines, and 7% for cancer. Participants also reported using medical cannabis to treat the symptoms of AIDS, glaucoma, muscle spasms, nausea, stress, and depression. Researchers found that medical cannabis was used at similar rates by men and women, the young and the old, patients with high and low levels of education, and in various regions of the state.
c) The voters of the State of California approved Proposition 215, the Compassionate Use Act of 1996 (codified as Health and Safety Code Section 11362.5), in 1996. That Act calls on "federal and state governments to implement a plan to provide for the safe and affordable distribution of

marijuana to all patients in medical need of marijuana."

d) The State enacted the Medical Marijuana Program Act (codified as Health and Safety Code Section 11362.7 et seq.) in 2004 to clarify the scope of The Compassionate Use Act of 1996, facilitate the prompt identification of qualified patients and primary caregivers, avoid unnecessary arrest and prosecution of these individuals, provide needed guidance to law enforcement officers, promote uniform and consistent application of the Act, and to allow local governing bodies to adopt and enforce rules and regulations consistent with the Act.
e) The State enacted three bills, which comprise the Medical Marijuana Regulation and Safety Act (MMRSA), in 2015. AB 243, AB 266, and SB 643, create statewide licensing and regulations for the lawful cultivation, manufacturing, distribution, transportation, sales, and testing of medical cannabis in the state.
f) The MMRSA requires local governments to license, permit, or approve commercial medical cannabis as a prerequisite for state licensing, including the commercial cultivation of medical cannabis. Therefore, local licensing of medical cannabis cultivation is an essential part of ensuring an adequate supply of safe and legal medicine for legitimate patients to use.
g) Local governments retain broad discretion in regulating the time, place, and manner of commercial medical cannabis cultivation within their jurisdiction under the MMRSA.
h) The American Herbal Products Association (AHPA), the leading voice in herbal products industry, published recommendations for regulators regarding medical cannabis cultivation and other activity in 2014. These recommendations show that the indoor and outdoor commercial cultivation of medical cannabis can be conducted in a manner that is safe, secure, and sustainable.
i) Research conducted by Americans for Safe Access (ASA), the nation's leading medical cannabis patient advocacy organization, show that sensible regulations for medical cannabis preserve safe and legal access for legitimate patients, while reducing crime and complaints in neighborhoods.

____ Definitions.

a) "Commercial Medical Cannabis Cultivation" means any activity involving the planting, growing, harvesting, drying, curing, grading, or trimming of cannabis for medical use, including nurseries, that is intended to be transported, processed, manufactured, distributed, dispensed, delivered, or sold in accordance with the Medical Marijuana Regulation and Safety Act (MMRSA) for use by medical cannabis patients in California pursuant to the Compassionate Use Act of 1996 (California Health and Safety Code Section 11362.5).
b) "Commercial Medical Cannabis Cultivators License" means a business license for Commercial Medical Cannabis Cultivation in <*name of jurisdiction*> issued pursuant to the Chapter

c) "Indoor Cultivation" means Commercial Medical Cannabis Cultivation inside a building using exclusively artificial light.
d) "Mix Light Cultivation" means Commercial Medical Cannabis Cultivation indoors or outdoors using a combination of artificial and natural light.
e) "Outdoor Cultivation" means Commercial Medical Cannabis Cultivation outdoors using exclusively sunlight.
f) "Primary Caregiver" has the same definition as in Section 11362.7 of the California Health and Safety Code.
g) "Qualified Patient" has the same definition as in Section 11362.5 of the California Health and Safety Code.

____ Local Licenses and Approvals Required.

a) Beginning <*effective date of local licensing requirement*>, no person shall engage in Commercial Medical Cannabis Cultivation in <*name of jurisdiction*> without first obtaining a Commercial Medical Cannabis Cultivators License.
b) A Commercial Medical Cannabis Cultivators License shall be issued by the <*name of city/county agency issuing license*> pursuant to the provisions of <*city/county code section specifying ordinary licensing process*>.
c) A Commercial Medical Cannabis Cultivators License shall be valid for one year and renewable annually thereafter.
d) The <*name of city/county agency issuing license*> may revoke a Commercial Medical Cannabis Cultivators License for violations of state and local law, including the provisions of the Chapter, pursuant to the procedures in <*city/county code section specifying ordinary process for suspending business licenses*>.
e) A Commercial Medical Cannabis Cultivators License holder shall also obtain all ordinary building permits, licenses, clearances, and approvals required for manufacturing or agricultural use at the address or parcel where medical cannabis cultivation is lawfully permitted pursuant to this Chapter.
f) The actions of a Commercial Medical Cannabis Cultivators License holder, its employees, and its agents that are permitted pursuant to the Chapter and conducted in accordance with the requirements of this Chapter are not unlawful and shall not be an offense subject to arrest, prosecution, or other sanction.
g) The actions of a person who, in good faith, allows his or her property to be used by a Commercial Medical Cannabis Cultivators License holder, its employees, and its agents, as permitted pursuant to the Chapter, are not unlawful and shall not be an offense subject to arrest, prosecution, or other sanction under state law, or be subject to a civil fine.

____ State License Required.

a) A Commercial Medical Cannabis Cultivators License holder shall obtain all state licenses and permits required under the Medical Marijuana Regulation and Safety Act (MMRSA), as amended from time to time, and any subsequent

state licensing or regulations duly adopted and enacted by the State or an authorized regulatory body.

b) Notwithstanding the provisions of Section (a), no state license or permit shall be required if state licenses are not yet available pursuant to the Medical Marijuana Regulation and Safety Act or the availability or validity of state licenses pursuant to the Medical Marijuana Regulation and Safety Act is interrupted, suspended, or revoked for any reason.

____ Approved Zones.

a) A Commercial Medical Cannabis Cultivators License may be issued in any zoning district approved for manufacturing or agriculture.
b) No Commercial Medical Cannabis Cultivators License shall be issued for any property that is located within six hundred feet of a public or private school (K-12).

____ Security.

a) Licensed Indoor Cultivation shall be conducted in a secured facility that is monitored at all times. Security equipment shall include, but not necessarily be limited to:
    1) Locking doors and windows,
    2) A remotely monitored alarm system that is operational at any time that the structure is not occupied by authorized persons,
    3) Video recording equipment and lighting that is sufficient to recognize an individual's face in the facility, and
    4) Video recording equipment that can store video recordings for up to seventy-two hours and download recordings onto a permanent storage device, as needed.
b) Parcels on Outdoor Cultivation or Mixed Light Cultivation are conducted must be secure. Security equipment shall include, but not necessarily be limited to, a fence surrounding the plants of not less than six feet in height with a locking gate.
c) No medical cannabis shall be cultivated in any structure or on any parcel if the medical cannabis plants are visible from any public place.
d) A Commercial Medical Cannabis Cultivators License holder shall maintain adequate security at all times to prevent burglary, robbery, diversion of medical cannabis for unlawful use, and nuisance activity in the immediate vicinity.
e) Any security personnel employed by or contracted by at Commercial Medical Cannabis Cultivators License holder shall, at a minimum, possess a valid Guard Card issued by the California Department of Consumer Affairs.

____ Qualified Patients and Primary Caregivers Exempted.

A Qualified Patient or Primary Caregiver cultivating medical cannabis for five or

fewer Qualified Patients shall not be subject to the provisions of this Chapter, provided that (1) all of the medical cannabis cultivated is for the personal medical use of the patient for whom it is cultivated, and (2) the Primary Caregiver only receives compensation for actual expenses, including reasonable compensation for services provided to a Qualified Patient to enable that person to lawfully use medical cannabis pursuant to State law, or for payment for out-of-pocket expenses incurred in providing those services in full compliance with Section 11362.765 of the California Health and Safety Code.

____ Severability.

The provisions of this Chapter are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

WHERE WILL MEDICAL MARIJUANA PATIENTS OBTAIN THEIR MEDICINE?

A whitepaper to guide communities in crafting equitable regulations for medical cannabis access

Prepared by
Americans for Safe Access

October 2015

National Office
1806 Vernon Street NW, Washington, D.C. 20009 PHONE: 202.857.4272 FAX: 202.857.4273

WEB: www.AmericansForSafeAccess.org TOLL FREE: 1.888.929.4367

Where Will Medical Marijuana Patients Obtain Their Medicine?

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ABOUT THIS REPORT

This report was produced by Americans for Safe Access (ASA). ASA is the largest national member-based organization of patients, medical professionals, scientists, and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research. ASA works in partnership with state, local and national legislators to overcome barriers and create policies that improve access to cannabis for patients and researchers. ASA has more than 100,000 active members in all 50 states. Learn more about ASA at AmericansForSafeAccess.org.

Americans for Safe Access Foundation

1806 Vernon Street NW, Washington, D.C. 20009

BACKGROUND

Since 1996, forty states, the District of Columbia, Puerto Rico, and Guam have passed laws that grant their residents the right to possess, cultivate, and/or obtain cannabis (marijuana) under the care of their physician.[1] These laws have been passed to address health-care needs of residents who may benefit from cannabis-based treatments, often where conventional medications have failed. These patient populations include people living with or treating cancer, multiple sclerosis, Crohn's Disease, ALS, epilepsy, Dravet's Syndrome (and other severe childhood epilepsy disorders), Post Traumatic Stress Disorder, and chronic pain. Twenty-three of these states and the District of Columbia have laws that include distribution programs regulated through state and local licensing and oversight. Medical cannabis patient access points, often called "dispensaries," are where most of these patients obtain their medicine. The final stage in implementing successful medical cannabis programs comes down to community zoning that allows these access points to operate in locations that take into consideration patients' needs.

"Local government has a responsibility to the medical needs of its people, even when it's not a politically easy choice to make. We have found it possible to build regulations that address the concerns of neighbors, local businesses, law enforcement and the general public, while not compromising the needs of the patients themselves. We've found that by working with all interested parities in advance of adopting an ordinance while keeping the patients' needs foremost, problems that may seem inevitable never arise."

Nancy J. Nadel, Oakland City Councilmember

Over the last twenty years, medical cannabis laws and regulations have evolved dramatically to address both consumer and community concerns, including product safety, zoning, and planning issues. Multiple studies have concluded that medical cannabis dispensaries have a positive impact on the communities in which they are located. Communities regulating these medical cannabis access points today can draw on the experiences of hundreds of cities and counties across the country to create polices that meet the needs of their patient populations while addressing concerns about community impact.

Americans for Safe Access (ASA) complied this report to provide policy makers at the state, county, and municipal level with relevant data to consider as they implement their state's medical cannabis law. The report is meant to demystify "dispensaries" and the people they serve, as well as summarize the local impact of regulated medical cannabis access points. Twenty years of experience shows that cities and counties can effectively address community concerns without denying patients access due to unfounded fears (e.g. NIMBY-ism, etc.) or misinformation.

"DISPENSARIES"

1. Sixteen of the 40 states have adopted what are sometimes called "CBD laws," due to their focus on cannabidiol (CBD) rather than the full range of cannabinoids. Most of these laws have seizure disorders as the lone qualifying condition.

Dispensaries are highly regulated retail access points where qualified patients can obtain their medication. They are a preferred alternative to the potentially dangerous and unregulated illicit market. From Washington, D.C. to South Windsor, Connecticut to Phoenix, Arizona, communities have regulated medical cannabis access points, or "dispensaries," to meet the needs of their residents. Successful medical cannabis programs consider the ability of patient populations to access dispensaries, including safety, proximity, access to public transit, and more.

"When designing regulations, it is crucial to remember that at its core this is a healthcare issue, requiring the involvement and leadership of local departments of public health. A pro-active healthcare-based approach can effectively address problems before they arise, and communities can design methods for safe, legal access to medical marijuana while keeping the patients' needs foremost."

Nathan Miley, Alameda County Supervisor

State regulations include a vetting process for the owners of medical cannabis business licenses, facility security protocols, and anti-diversion strategies. City and county regulations usually have the same permitting and mitigation discretion as any other types of business (e.g. zoning, hours of operation, and parking accommodation). These access points are the final step in a regulated supply chain developed to serve the patient population in a city or county.

Today, state regulatory programs are trending toward the adoption of product safety and quality control standards developed by the American Herbal Products Association (AHPA). These best-practice standards include cannabis product safety protocols, proper staff training, and guidance for dispensary security operations.

BENEFITS OF MEDICAL CANNABIS DISPENSARIES

After nearly two decades of existence, dispensaries have proven to be an asset to the populations they serve, as well as the larger community in which they operate. Research shows that once effective regulations are in place, dispensaries are typically viewed favorably by public officials, neighbors, businesses, and the community at large and that regulatory ordinances improve areas both socially and economically. Public officials in both urban and rural communities across the country have been outspoken in praise of the dispensary regulatory schemes they enacted and the benefits to the patients and others living in their communities.

Medical cannabis dispensaries provide a benefit to the community by allowing patients to have convenient, safe, and legal access to their physician-recommended therapeutic regimen. These retail access points provide a regulated system by which patients can obtain their medicine under controls for safety and reliability.

When a local government prohibits safe and legal access, patients are forced to make at least one of several sub-optimal choices. They may deal with the burden of travel, which means they will incur extra expense and lose time on the roundtrip journey to a

neighboring jurisdiction, if not further. These problems are compounded if the patient has mobility issues. If legal access proves to be too burdensome, patients may feel compelled to turn to the illicit market, which is completely unregulated and defeats the purpose of the state's intent in passing medical cannabis legislation.

Dispensaries help revitalize neighborhoods by reducing crime and bringing new customers to surrounding businesses. They help provide a modest improvement to public safety by increasing the security presence in neighborhoods. While medical cannabis laws should not be designed or regulated to be a jobs program, these new businesses provide a secondary asset by employing members of the community.

Benefits to public health have also been identified. The availability of a robust state medical cannabis program correlates to significant reductions in unintentional opioid overdose deaths. An early study suggested that recommending "cannabis in place of opioids for neuropathic pain may reduce the morbidity and mortality rates associated with prescription pain medications and may be an effective harm reduction strategy."[2] That prediction has been borne out by recent studies.

"Medical cannabis dispensaries are serving a vital service to residents in the District of Columbia. Well regulated dispensaries are the only legal outlet where patients can obtain this physician-recommended therapeutic treatment option. Some of these patients may have previously not have had access to cannabis prior to the program, while other may have been obtaining it through unregulated sources. In either case, it is far preferable to have our vulnerable patients obtaining their medicine from entities regulated by the Department of Health."

Dr. Rikin Mehta, Senior Deputy Director, D.C. Health Regulation and Licensing Administration

A 2014 study published by JAMA Internal Medicine looked at ten medical cannabis states from 1999 to 2010 and found "[s]tates with medical cannabis laws had a 24.8% lower mean annual opioid overdose mortality rate...compared with states without medical cannabis laws."[3] Most recently, a 2015 study by researchers associated with the RAND Corporation, the National Bureau of Economic Research and University of California, Irvine concluded:

> ...states permitting medical marijuana dispensaries experience a relative decrease in both opioid addictions and opioid overdose deaths compared to states that do not. Our findings suggest that providing broader access to medical marijuana may have the potential benefit of reducing abuse of highly addictive painkillers.[4]

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2. Collen, Mark, Prescribing Cannabis for Harm Reduction, Harm Reduct J. 2012; 9: 1., available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3295721
3. Bachhuber, Marcus, et al., Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010, JAMA Internal Medicine, Oct. 2014, available at: http://archinte.jamanetwork.com/article.aspx?articleid=1898878
4. Powell, David, et al. Do Medical Marijuana Laws Reduce Addictions and Deaths Related to Pain Killers? NBER Working Paper No. 21345, July 2015. Abstract available at: https://www.aei.org/publication/increased-marijuana-use-for-chronic-pain-reduces-addictions-and-deaths-related-to-opioid-pain-killers/

POPULATIONS SERVED BY DISPENSARIES

Under many of the early medical cannabis laws, patients were largely reliant upon personal cultivation or collective gardening as their means to obtain their physician-recommended medicine. But as more states have adopted medical cannabis laws, the emphasis from patient/caregiver cultivation has shifted towards the dispensary model. Dispensaries benefit the community by providing safe access for those who have the greatest difficulty getting the medicine their doctors' recommend: the most seriously ill and injured. Over two million patients now have safe access to their medicine through dispensaries. This means that the patient population that is served by dispensaries is as diverse as the patient population itself.

"[D]ispensaries have not presented any harms to the communities where they are located. Once a dispensary opens, it tends to blend in with the rest of the community, but provides the added benefit of extra security cameras on the blocks where they are located."

Dr. Rikin Mehta, Senior Deputy Director, D.C. Health Regulation and Licensing Administration

The population served by medical cannabis dispensaries reflects all walks of life. However, the specifics of a given state law can shape the demographics of the population served. For example, in the several states where distribution programs offer discounts to patients living with financial hardship, there is broader demographic inclusion. States without such provisions may inadvertently be excluding financially challenged patients because medical cannabis is not covered by health insurance. States that force their dispensaries to operate in industrial areas far from public transportation may also be at risk of unintentionally excluding financially vulnerable patients due to the time and cost burdens associated with obtaining medicine.

Additionally, the state's laws and regulations regarding qualifying conditions will impact who is eligible. Some states take the view that, unlike prescription medication, medical cannabis can only be recommended for certain conditions, that conditions must be of extreme severity, and that the patients must have exhausted all other available options before being able to gain safe and legal access. This means that patients who will not respond to conventional medication must experience pain, trauma, lost wages, and lost time with their loved ones before finding relief through medical cannabis. Because patients are subjected to these external discriminatory forces, the retail access points where patients obtain their medicine should not present additional hurdles such as onerous zoning that makes the closest or most reliable dispensary difficult to reach.

Ultimately, it is important to remember that medical cannabis patients look like ordinary people facing medical hardship. While critics of medical cannabis programs frequently claim that some patients who rely on medical cannabis do not look "sick enough" to justify medical cannabis access, it is often because they do not understand how effective this medicine can be. Medical cannabis can enable patients to return to work. And in other cases, it may allow a patient with a terminal condition to have quality time with their loved ones instead of being heavily drugged on morphine or other heavy prescription medication.

While the medical cannabis population is as diverse as the general population, one thing patients have in common is that the overwhelming majority of them now rely dispensaries for their access to medical cannabis.

Demographics

A peer-reviewed study that examined California medical cannabis patient data found that the population is fairly evenly distributed by age, with about 18% ages 18-24; 28% ages 25-34; 22% ages 35-44; 19% ages 45-54; and 13% over 55. The report also found that medical cannabis patients do not "immediately seek marijuana recommendations as the first strategy to deal with their symptoms," but rather that "these individuals tried more traditional forms of medicine."[5]

The most recent set of data made available by the Arizona Department of Health Services shows that patients ages 18-30 make up about 24% of the patient population; ages 31-40: 20%; ages 41-50: 16%; ages 51-60: 20%; ages 60+: 20%.[6] The New Mexico Department of Health conducted a patient survey finding that the states patients typically "range from 19 to 83 years of age, with an average age of 49.9 years old."[7]

"There should be 6,000 registered patients by the end of the year [a 50% increase from June 2015]....This is not just about today, this is about being ahead of the curve."

Jonathan Harris, Connecticut Commissioner of Consumer Protection on proposal to approve the maximum number of new dispensaries

A small study of one Michigan dispensary yielded similar age distribution, noting that, "on average, participants in this study were 41.5 years of age (SD = 12.6), with half of them at least 50 years of age. The report also found that medical marijuana therapy demonstrated efficacy as, "returning patients reported somewhat lower scores on measures of current pain and slightly higher scores on measures of mental health and physical functioning than did first time patients."[8]

DISPENSARIES AND CRIME – PERCEPTION VS. REALITY

Looking at nearly two decades of data, crime statistics and the accounts of local officials indicate that crime is reduced by the presence of a dispensary. In fact, the overwhelming preponderance of studies point in the direction that dispensaries have either a neutral or slightly dampening effect upon crime in the community.

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5. Nunberg, Helen, et at., An Analysis of Applicants Presenting to a Medical Marijuana Specialty Practice in California, J Drug Policy Anal. 2011 Feb; 4(1): 1., available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673028/
6. Arizona Medical Marijuana Program July 2015 Monthly Report, Arizona Dept. of Health Services, available at: http://azdhs.gov/documents/licensing/medical-marijuana/reports/2015/2015-july-monthly-report.pdf
7. Medical Cannabis Survey 2013, New Mexico Dept. of Health, available at: http://nmhealth.org/publication/view/report/140/
8. Ilgen MA, et al., Characteristics of Adults Seeking Medical Marijuana Certification, Drug Alcohol Depend. 2013 Oct 1;132(3):654-9, available at: http://www.ncbi.nlm.nih.gov/pubmed/23683791

The presence of a dispensary in the neighborhood can improve public safety and reduce crime.[9] Most dispensaries take security for their members and staff more seriously than many other businesses. Security cameras are often used both inside and outside the premises, and security guards are often employed to ensure safety. Both cameras and security guards serve as a general deterrent to criminal activity and other problems on the street. Those likely to engage in such activities tend to move to a less-monitored area, thereby ensuring a safe environment not only for dispensary members and staff but also for neighbors and businesses in the surrounding area.

"The areas around the dispensaries may be some of the safest areas of Oakland now because of the level of security, surveillance, etc...since the ordinance passed."

Barbara Killey, Oakland city administrator responsible for oversight of dispensaries

An ordinance in Oakland requires dispensaries to develop a security plan that had must be reviewed by regulatory officials prior to licensure. Other communities in California have followed suit with similar local ordinances. This emphasis on security that was developed in the California medical cannabis system has since evolved and become the national gold standard, from Nevada to Maryland, Maine, and Illinois.

Studies on Dispensaries and Crime

The absence of any connection between dispensaries and increased local crime can be seen in data from Los Angeles, San Diego, Denver, and Colorado Springs. After reviewing a study he commissioned, Los Angeles Police Chief Charlie Beck observed that, "banks are more likely to get robbed than medical cannabis dispensaries," and that the claim that dispensaries attract crime "doesn't really bear out."[10]

In San Diego, where some officials have made allegations about increased crime associated with dispensaries, an examination of city police reports by a local paper, the San Diego CityBeat, found that as of late 2009 the number of crimes in areas with dispensaries was frequently lower than it was before the dispensary opened or, at worst, stayed the same.[11]

"I don't think the data really supports [the idea that dispensaries] are more likely to be targeted at this point."

Sgt. Darrin Abbink, Colorado Springs Police spokesperson, commenting on crime rates

A 2009 analysis of robbery and burglary rates at medical cannabis dispensaries conducted by the Denver, Colorado Police Department at the request of the Denver City Council found that the robbery and burglary rates at dispensaries were lower than area

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9. See review of available studies in subsection below. There is one non-peer reviewed study, by PhD. candidate Catherine Alfred of the University of Virgina, that reached the conclusion that dispensaries may increase certain kinds of crime when not accompanied by the right to home cultivation. She speculates that the exacerbating factor may have been the result of slow implementation and low statutory caps on the number of dispensaries, citing New Jersey as an example. The suggestion that dispensaries increase crime runs counter to other evidence.
10. Castro, Tony. "LAPD chief: Pot clinics not plagued by crime." *LA Daily News,* Jan 17, 2010.
11. Maass, Dave. "Prosecutors use dubious claims to attack collectives." *San Diego City Beat,* Oct 26, 2011.

banks and liquor stores, and on par with those of pharmacies. Specifically, the report found a 16.8 percent burglary and robbery rate for dispensaries, equal to that of pharmacies. That's lower than the 19.7 percent rate for liquor stores and the 33.7 percent rate for banks the analysis found.[12]

A 2010 analysis by the Colorado Springs Police Department found that robbery and burglary rates at area dispensaries were on par with those of other businesses.[13]

"They have been a responsible neighbor and vital organization to our diverse community. Since their opening, they have done an outstanding job keeping the building clean, neat, organized and safe. In fact, we have had no calls from neighbors complaining about them, which is a sign of respect from the community. In Berkeley, even average restaurants and stores have complaints from neighbors."

Kriss Worthington, Berkeley City Councilmember

In 2012, a study published in the *Journal of Studies on Alcohol and Drugs* explored the issue of dispensaries and crime in Sacramento, California. Among the conclusions of the report is the following:

> There were no observed cross-sectional associations between the density of medical marijuana dispensaries and either violent or property crime rates in this study. These results suggest that the density of medical marijuana dispensaries may not be associated with crime rates or that other factors, such as measures dispensaries take to reduce crime (i.e., doormen, video cameras), may increase guardianship such that it deters possible motivated offenders.[14]

A 2013 report found no difference in crime rate changes between neighborhoods in Denver with dispensaries and those without, noting that "crime near dispensaries was up 1.8 percent, *in line with the slight increase in crime in the whole city for that period.*" [emphasis added].[15]

A multi-state study published in 2014 noted that medical cannabis laws are associated with a small but measurable decrease in crime, including some surprising decreases in subsequent years. Among the study's findings were:

> First, the impact of MML [medical marijuana law] on crime was negative or not statistically significant in all but one of the models, suggesting *the passage of MML may have a dampening effect on certain crimes*. The second key finding was that the coefficients capturing the impact of MML on homicide and assault were the only two that emerged as statistically significant. Specifically, the results indicate approximately a 2.4 percent reduction in homicide and assault, respectively, for each additional year the law is in effect. [emphasis added]

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12. Ingold, John. "Analysis: Denver pot shops' robbery rate lower than banks." *Denver Post*. Jan 27, 2010.
13. Rogers, Jakob"Marijuana shops not magnets for crime, police say," *Fort Collins Gazette*, September 14, 2010.
14. Kepple NJ, Freisthler B. "Exploring the ecological association between crime and medical marijuana dispensaries.J Stud Alcohol Drugs. 2012 Jul;73(4):523-30. Accessible at http://www.ncbi.nlm.nih.gov/pubmed/22630790
15. Ingold, John and Meyers, Jeremy. "Slight increase in crimes near Denver medical-marijuana dispensaries." *Denver Post*, Aug 1, 2013.

The report concluded by saying:

> The central finding gleaned from the present study was that MML is not predictive of higher crime rates and may be related to reductions in rates of homicide and assault. Interestingly, robbery and burglary rates were unaffected by medicinal marijuana legislation, which runs counter to the claim that dispensaries and grow houses lead to an increase in victimization due to the opportunity structures linked to the amount of drugs and cash that are present. Although, this is in line with prior research suggesting that medical marijuana dispensaries may actually reduce crime in the immediate vicinity....[16]

In sum, these findings run counter to arguments suggesting the legalization of marijuana for medical purposes poses a danger to public health in terms of exposure to violent crime and property crimes. To be sure, medical marijuana laws were not found to have a crime exacerbating effect on any of the seven crime types.

UNFOUNDED FEARS CONCERNING TEEN USE

A common fear that dispensaries will increase teen use of marijuana often result in overly restrictive zoning for patient access. However, the available evidence suggests that those fears are unfounded. Two recent studies have concluded that teen marijuana has decreased nationally. Federal data states that from 2002 to 2014, as medical cannabis programs proliferated across the country, teen use (ages 12-17) of cannabis in the previous 30 days fell from 8.2% to 7.4% and that past year dependence of cannabis by the same age group fell by about 10%.[17]

"(C)oncerns that increased adolescent marijuana use is an unintended effect of state medical marijuana laws seem unfounded."

Lancet 2015

A study by Johns Hopkins University Bloomberg School of Public Health examining the impact of changes in cannabis laws on teen use from 1999 to 2013 found, "[d]espite considerable changes in state marijuana policies over the past 15 years, marijuana use among high school students has largely declined."[18]

A July 2015 study published by the Lancet that looked directly at the impact of state medical marijuana laws on teen use reach the following conclusion:

> In conclusion, the results of this study showed no evidence for an increase in adolescent marijuana use after passage of state laws permitting use of marijuana

16. Morris, Et al. "The Effect of Medical Marijuana Laws on Crime: Evidence from State Panel Data, 1990-2006" PLoS One. 2014; 9(3): e92816. Accessible at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3966811/
17. Hedden, Sarra, et al, Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, Supplemental Tables of Estimates for Behavioral Health Trends in the United States, Substance Abuse and Mental Health Services Administration, available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm#idtextanchor142
18. Johnson, Rene, et al., Past 15-year trends in adolescent marijuana use: Differences by race/ethnicity and sex, Drug and Alcohol Dependence, Sept. 2015, available at: http://www.drugandalcoholdependence.com/article/S0376-8716(15)01618-X/abstract

for medical purposes...However, concerns that increased adolescent marijuana use is an unintended effect of state medical marijuana laws seem unfounded. [19]

FEDERAL PREEMPTION DOES NOT IMPEDE STATE PROGRAMS

Ideally, federal, state, and local law would allow for patients to safely and legally obtain medical cannabis from a retail dispensary. However, the fact that federal law does not currently recognize medical cannabis does not preclude state and local governments from adopting and implementing their own medical cannabis programs. In fact, the federal Department of Justice (DOJ) is now forbidden by Congressional budgetary language know as the Rohrabacher-Farr Amendment[20] from taking action against state and local officials for attempting to implement their medical cannabis laws and regulations.

A report by the Congressional Research Service found that, "[s]tate laws that exempt from state criminal sanctions the cultivation, distribution, or possession of marijuana for medical purposes have generally not been preempted by federal law."[21] The report notes that the case of *Gonzales v. Raich*, which allows the federal government to enforce against intrastate medical cannabis production, was not a federal preemption case and is silent on the issue.[22] The report goes on to demonstrate that the Tenth Amendment and the cases of *New York v. United States* and *Printz v. United States* clearly show that the federal government cannot commandeer state legislatures or administrative agencies. Therefore, Congress may not force state or local police to enforce the federal Controlled Substances Act.

Additionally, the DOJ has issued an internal memo in February 2015 regarding the Rohrabacher-Farr Amendment impact on the Department's ability to prosecute in medical cannabis states. The legislative intent of the amendment is to prohibit DOJ from interfering with anyone participating in state-legal medical cannabis conduct. The Department concedes that the amendment, "prohibit the expenditure of the Department's 2015 appropriations on civil litigation regarding State laws authorizing the medical use of marijuana where the State or State officials are a party.[23]

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19. H.R. 83, 113 Cong. (enacted). Print. p. 213-214, available online at: http://docs.house.gov/billsthisweek/20141208/CPRT-113-HPRT-RU00-HR83sa.pdf
20. Hasin, Deborah S. et al., Medical marijuana laws and adolescent marijuana use in the USA from 1991 to 2014: results from annual, repeated cross-sectional surveys, *The Lancet*, June 15, 2015, available at: http://www.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(15)00217-5.pdf
21. Garvey, Todd, Medical Marijuana: The Supremacy Clause, Federalism, and the Interplay Between State and Federal Laws, Congressional Research Service, November 9, 2012. Available at: ttps://www.fas.org/sgp/crs/misc/R42398.pdf
22. In practice, the preponderance of cases related to federal preemption of state medical marijuana laws have ruled that the laws are not preempted. One case in Oregon held that a certain portion of the state law was preempted, but that proved to be more of a technical point, as the program was allowed to largely proceed without related hindrance after the ruling.
23. Guidance Regarding the Effect of Section 538 of the Consolidated and Further Continuing Appropriations Act of 2015 on Prosecutions and Civil Enforcement and Forfeiture Actions Under the Controlled Substances Act, U.S. Dept. of Justice memorandum to All Federal Prosecutors, February 27, 2015.

DIVERSION ADDRESSED THROUGH STATE REGULATION

One of the concerns of public officials is that dispensaries make possible or even encourage the resale of cannabis on the street. But cities where dispensaries are well regulated have not encountered such problems. In addition to being monitored by law enforcement, dispensaries typically have strict rules about how members are to behave in and around the facility. Many have "good neighbor" policies for their members that emphasize sensitivity to the concerns of neighbors and prohibit the resale of cannabis. Anyone violating that prohibition is typically banned from any further contact with the dispensary and can be barred from the state program all together.

"...[P]eople feel safer when they're walking down the street. The level of cannabis street sales has significantly reduced."

Lupe Schoenberger, Legislative Analyst, City of Oakland

Each state has addressed the issue of diversion of medical cannabis to some extent. This component became more prominent in state medical cannabis laws following issuance of the 2013 U.S. Department of Justice memo on cannabis prosecutorial guidance, commonly referred to as the 2013 Cole Memo.[24] Because this issue is addressed by the state law and regulations, it is unnecessary for municipal governments to take additional steps to ensure compliance with DOJ guidance. Most state regulations have specific requirements on labeling and product safety, such as child proof containers, that also play a role in addressing diversion.

CONCLUSION

Properly regulated medical cannabis dispensaries are an essential component of any successful state medical cannabis program. Community zoning determines how (and if) residents will be able to benefit from these laws. Experience shows that well-regulated dispensaries are responsible neighbors and valued members of the community. They bring jobs and increased economic activity while providing patients suffering from serious illnesses with an essential physician-recommended medicine.

In deciding where and how these businesses are allowed to operate, policymakers can look to the experience of other local governments to devise workable strategies. Decades of experience show the needs of legal patients and the community at large can be balanced. Cities and counties can zone and regulate access points in a win-win scenario. To do this, policy makers must be responsive all of the stakeholders and avoid making decisions based on bias and misinformation.

ASA works closely with lawmakers, regulators, and other stakeholders at every level of government to find solutions that work for patients and their communities. Contact ASA at policy@safeaccessnow.org or (202) 857-4272 for more information and assistance in implementing sensible zoning rules and regulations for your city or county.

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24. Cole, J. (2013). Memorandum for all United States attorneys [Re:] Guidance Regarding Marijuana Enforcement. United States, Department of Justice, Office of Legal Counsel. available online at: http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf

MODEL LOCAL MEDICAL CANNABIS DISPENSARY ORDINANCE

The following is a generic ordinance developed by Americans for Safe Access. The contents have been derived from various city and/or county ordinances, as well as lessons from the experiences of cities and/or counties implementing laws of this nature nationwide. Some aspects of this ordinance may not apply to your jurisdiction; furthermore, there may be additional requirements established in state law. If you need additional support in drafting language, please contact us at policy@safaccessnow.org.

Purposes and Intent

(1) To implement the provisions of ____ (state law) with respect to local zoning and land use.

(2) To help ensure that seriously ill _____ (county/city) residents can obtain and use cannabis for medical purposes where that medical use has been deemed appropriate by a physician in accordance with ____ (state) law.

(3) To establish a new section in the _____ code pertaining to the permitted distribution of medical cannabis in _____ consistent with state law. Nothing in this Chapter purports to permit activities that are otherwise illegal under state or local law.

(4) Nothing in this Chapter is intended to reduce the rights of a Qualified Patient or Primary Caregiver otherwise authorized by _____ (state law) .

[for states that allow personal cultivation] (5) To help ensure that the Qualified Patients and their Primary Caregivers who obtain or cultivate cannabis solely for the Qualified Patient's medical treatment are not subject to arrest,criminal prosecution, or sanction.

(6) To prevent the diversion of medical cannabis for unlawful use and protect the safety and welfare of the community.

Definitions

The following phrases, when used in this Chapter,shall be construed as defined in ____ (state law):

"Medical Cannabis Dispensary"

"Primary Caregiver;" and

"Qualified Patient."

Location

The location at which an Medical Cannabis Dispensary distributes medical cannabis must meet the following requirements:

(1) The location must be in a Non-Residential Zone appropriate for Commercial, Manufacturing, or Retail uses, including health care use;

(2) The location

(a) must not be within a 500-foot radius of a school, as measured from edge of the parameter, and

(b) a school that opens after the date that a dispensary applies for licensure from the state, or a school that is permanently closed on the date the dispensary application to the state is submitted shall not be considered for the purposes of subsection (2)(a) of this section; and

(3) The location must not be within 1,000 feet of another Medical Cannabis Dispensary.

Police Department Procedures and Training

Within six months of the date that this Chapter becomes effective, training materials, handbooks, and printed procedures of the Police Department shall be updated to reflect its provisions. These updated materials shall be made available to police officers in the regular course of their training and service.

(1) Qualified Patients and their Primary Caregivers who come into contact with law enforcement shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if they are in compliance with the provisions of this Chapter.

(2) Qualified Patients and their Primary Caregivers who come into contact with law enforcement and cannot establish or demonstrate their status as a Qualified Patient, Primary Caregiver, but are otherwise in compliance with the provisions of this Chapter,shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if

(a) based on the activity and circumstances, the officer determines that there is no evidence of criminal activity;

(b) the claim by a Qualified Patient or a Primary Caregiver is credible; or

(c) proof of status as a Qualified Patient or Primary Caregiver can be provided to the Police Department within three (3) business days of the date of contact with law enforcement.

(3) The Police/Sheriff's Department and any agent or contractor acting on behalf of ____ (city/county) shall enforce all civil and criminal ordinances related to Medical Cannabis Dispensaries, employees, and clients in a manner that is consistent with other legally licensed/permitted businesses in the city/county. No additional restrictions other than defined in this Chapter shall be applied or enforced.

(4) Medical cannabis-related activities shall be the lowest possible priority of the ____ (City/County) Police/Sheriff's Department.

Medical Cannabis Dispensary Operational Standards

(1) Medical Cannabis Dispensaries must obtain all necessary state and local license/permits before commencing operations and shall maintain a valid license/permit during any period of operation;

(2) No Medical Cannabis Dispensary may provide medical cannabis to any persons other than Qualified Patients and Primary Caregivers whose status to possess cannabis pursuant to state law has been verified. No medical cannabis provided to a Primary Caregiver may be supplied to any person(s) other than the Qualified Patient(s) who designated the Primary Caregiver. No Medical Cannabis Dispensary shall provide medical cannabis to any Qualified Patient or Primary Caregiver if it is known that the Qualified Patient or Primary Caregiver is diverting medical cannabis for unlawful use;

(3) Medical Cannabis Dispensaries must demonstrate compliance with state in law in the areas of security plans, inventory records, patient records, product safety, product labeling, disposal protocols and recall strategies.

(4) Medical Cannabis Dispensaries must establish "good-neighbor" policies for patients and Primary Caregivers visiting the location that includes at a minimum parking instructions and prohibition of using medicine on and around location. A copy of the policies must be posted in a conspicuous location inside the facility;

(5) A Medical Cannabis Dispensary shall provide a neighborhood security guard patrol for a two-block radius surrounding the collective during all hours of operation;

(6) Interior building lighting, exterior building lighting and parking area lighting must be in compliance with applicable regulations, and must be of sufficient brightness and color rendition so as to allow the ready identification of any individual committing a crime on site at a distance of no less than 40 feet (a distance that should allow a person reasonable reaction time upon recognition of a viable threat);

(7) Absolutely no cannabis product may be visible from the building exterior;

(8) No persons under the age of 18 shall be allowed on site, unless the individual is a Qualified Patient and accompanied by his or her parent or documented legal guardian;

(9) [If cultivation at a Medical Cannabis Dispensary is allowed by state law] No outdoor cultivation shall occur at a Medical Cannabis Dispensary location unless it is: a) not visible from anywhere outside of the Medical Cannabis Dispensary property and b) secured from public access by means of a locked gate and any other security measures necessary to prevent unauthorized entry;

(10) No Medical Cannabis Dispensary shall permit the sale or dispensing of alcoholic beverages for consumption on the premises or offsite of the premises;

(11) No dried medical cannabis shall be stored in structures without at least four walls and a roof, or stored in an unlocked vault or safe, or other unsecured storage structure; nor shall any dried medical cannabis be stored in a safe or vault that is not bolted to the floor or structure of the facility;

(12) Operating hours for Medical Cannabis Dispensaries shall not exceed the hours between 6:00 AM and 10:00 PM daily; and

(13) Signs displayed on the exterior and interior of the property shall conform to state and city regulations.

Severability

If any section, sub-section, paragraph, sentence, or word of this Chapter is deemed to be invalid, the invalidity of such provision shall not affect the validity of any other sections, sub-sections, paragraphs, sentences, or words of this Chapter, or the application thereof; and to that end, the sections, sub-sections, paragraphs,sentences, and words of this Chapter shall be deemed severable.

Americans For Safe Access

AN ORGANIZATION OF MEDICAL PROFESSIONALS, SCIENTISTS, AND PATIENTS HELPING PATIENTS

MEDICAL CANNABIS DISPENSING COLLECTIVES AND LOCAL REGULATION

AmericansFor SafeAccess

Advancing Legal Medical Marijuana Therapeutics and Research

MEDICAL CANNABIS DISPENSING COLLECTIVES AND LOCAL REGULATION

February 2011

Americans For Safe Access

AN ORGANIZATION OF MEDICAL PROFESSIONALS, SCIENTISTS AND PATIENTS HELPING PATIENTS

EXECUTIVE SUMMARY

California's original medical cannabis law, the Compassionate Use Act of 1996 (Prop. 215), encouraged state and federal governments to develop programs for safe and affordable distribution of medical cannabis (marijuana). Although self-regulated medical cannabis dispensing collectives (dispensaries) have existed for more than 14 years in California, the passage of state legislation (SB 420) in 2003, court rulings in *People v. Urziceanu* (2005) and *County of Butte v. Superior Court* (2009), and guidelines from the state Attorney General, all recognized and affirmed their status as legal entities under state law. With most of the 300,000 cannabis patients in California relying on dispensaries for their medicine, local officials across the state are developing regulatory ordinances that address business licensing, zoning, and other safety and operational requirements that meet the needs of patients and the community.

Americans for Safe Access, the leading national organization representing the interests of medical cannabis patients and their doctors, has undertaken a study of the experience of those communities that have dispensary ordinances to act as a guide to policy makers tackling dispensary regulations in their communities. The report that follows details those experiences, as related by local officials; it also covers some of the political background and current legal status of dispensaries, outlines important issues to consider in drafting dispensary regulations, and summarizes a recent study by a University of California, Berkeley researcher on the community benefits of dispensaries. In short, this report describes:

Benefits of regulated dispensaries to communities include:

- providing access for the most seriously ill and injured,
- offering a safer environment for patients than having to buy on the illicit market,
- improving the health of patients through social support,
- helping patients with other social services, such as food and housing,
- having a greater than average customer satisfaction rating for health care.

Creating dispensary regulations combats crime because:

- dispensary security reduces crime in the vicinity,
- street sales tend to decrease,
- patients and operators are vigilant; any criminal activity is reported to police.

Regulated dispensaries are:

- legal under California state law,
- helping revitalize neighborhoods,
- bringing new customers to neighboring businesses,
- not a source of community complaints.

This report concludes with a section outlining the important elements for local officials to consider as they move forward with regulations for dispensaries. ASA has worked successfully with officials across the state to craft ordinances that meet the state's legal requirements, as well as the needs of patients and the larger community.

Please contact us if you have questions: 888-929-4367.

OVERVIEW OF MEDICAL CANNABIS DISPENSARIES

"As the number of patients in the state of California who rely upon medical cannabis for their treatment continues to grow, it is increasingly imperative that cities and counties address the issue of dispensaries in our respective communities. In the city of Oakland we recognized this need and adopted an ordinance which balances patients' need for safe access to treatment while reassuring the community that these dispensaries are run right. A tangential benefit of the dispensaries has been that they have helped to stimulate economic development in the areas where they are located."

—Desley Brooks, Oakland City Councilmember

ABOUT THIS REPORT

Land-use decisions are now part of the implementation of California's medical marijuana, or cannabis, laws. As a result, medical cannabis dispensing collectives (dispensaries) are the subject of considerable debate by planning and other local officials. Dispensaries have been operating openly in many communities since the passage of Proposition 215 in 1996. As a compassionate, community-based response to the problems patients face in trying to access cannabis, dispensaries are currently used by more than half of all patients in the state and are essential to those most seriously ill or injured. Since 2003, when the legislature further implemented state law by expressly addressing the issue of patient collectives and compensation for cannabis, more dispensaries have opened and more communities have been faced with questions about business permits and land use options.

In an attempt to clarify the issues involved, Americans for Safe Access has conducted a survey of local officials in addition to continuously tracking regulatory activity throughout the state (see AmericansForSafeAccess.org/regulations). The report that follows outlines some of the underlying questions and provides an overview of the experiences of cities and counties around the state. In many parts of California, dispensaries have operated responsibly and provided essential services to the most needy without local intervention, but city and county officials are also considering how to arrive at the most effective regulations for their community, ones that respect the rights of patients for safe and legal access within the context of the larger community.

ABOUT AMERICANS FOR SAFE ACCESS

Americans for Safe Access (ASA) is the largest national member-based organization of patients, medical professionals, scientists, and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research. ASA works in partnership with state, local and national legislators to overcome barriers and create policies that improve access to cannabis for patients and researchers. We have more than 50,000 active members with chapters and affiliates in all 50 states.

THE NATIONAL POLITICAL LANDSCAPE

A substantial majority of Americans support safe and legal access to medical cannabis. Public opinion polls in every part of the country show majority support cutting across political and demographic lines. Among them, a Time/CNN poll in 2002 showed 80% national support; a survey of AARP members in 2004 showed 72% of older Americans support legal access, with those in the western states polling 82% in favor. The two largest physician-based professional organizations in the U.S., the American Medical Association and the

American College of Physicians, have urged the federal government to reconsider its regulatory classification of cannabis.

For decades, the federal government has maintained the position that cannabis has no medical value, despite the overwhelming evidence of marijuana's medical efficacy and the broad public support for its use. Not to be deterred, Americans have turned to state-based solutions. The laws passed by voters and legislators are intended to mitigate the effects of the federal government's prohibition on medical cannabis by allowing qualified patients to use it without state or local interference.

Fifteen states have adopted medical marijuana laws in the U.S. Beginning with California in 1996, voters passed initiatives in nine states plus the District of Columbia—Alaska, Arizona, Colorado, Maine, Michigan, Montana, Nevada, Oregon, and Washington. State legislatures followed suit, with elected officials in Hawaii, Maryland, New Jersey, New Mexico, Rhode Island, and Vermont taking action to protect patients from criminal penalty. Understanding the need to address safe and affordable access to medical cannabis, Arizona, California, Colorado, Maine, New Jersey, New Mexico, and Rhode Island all adopted local or state laws that regulate its production and distribution.

Despite *Gonzales v. Raich*, a U.S. Supreme Court ruling in 2005 that gave government the discretion to enforce federal cannabis laws even in medical cannabis states, more states continue to adopt laws each year.

With the election of President Barack Obama, a new approach to medical cannabis is taking shape. In October 2009, the Justice Department issued guidelines discouraging U.S. Attorneys from investigating and prosecuting medical cannabis cases. While this new policy specifically addresses enforcement, ASA continues to work with Congress and the President to push for expanded research and protection for all medical cannabis in the U.S. The public advocacy of well-known cannabis patients such as the Emmy-winning talk show host Montel Williams and music artist Melissa Etheridge has also increased public awareness and helped to create political pressure for changes in state and federal policies.

HISTORY OF MEDICAL CANNABIS IN CALIFORNIA

Since 1996, when 56% of California voters approved the Compassionate Use Act (CUA), public support for safe and legal access to medical cannabis has steadily increased. A statewide Field poll in 2004 found that "three in four voters (74%) favors implementation of the law." In 2003, the state legislature recognized that the Compassionate Use Act (CUA) gave little direction to local officials, which greatly impeded the safe and legal access to medical cannabis envisioned by voters.

Legislators passed Senate Bill 420, the Medical Marijuana Program (MMP) Act, which provided a greater blueprint for the implementation of California's medical cannabis law. Since the passage of the MMP, ASA has been responsible for multiple landmark court cases, including *City of Garden Grove v. Superior Court*, *County of San Diego v. San Diego NORML*, and *County of Butte v. Superior Court*. Such cases affirm and expand the rights granted by the CUA and MMP, and at the same time help local officials better implement state law.

In August 2008, California's Attorney General issued a directive to law enforcement on state medical marijuana law. In addition to reviewing the rights and responsibilities of patients and their caregivers, the guidelines affirmed the legality of storefront dispensaries and outlined a set of requirements for state law compliance. The attorney general guidelines also represent a roadmap by which local officials can develop regulatory ordinances for dispensaries.

WHAT IS A MEDICAL CANNABIS DISPENSING COLLECTIVE?

The majority of medical marijuana (cannabis) patients cannot cultivate their medicine for

themselves and cannot find a caregiver to grow it for them. Most of California's estimated 300,000 patients obtain their medicine from a Medical Cannabis Dispensing Collective (MCDC), often referred to as a "dispensary." Dispensaries are typically storefront facilities that provide medical cannabis and other services to patients in need. As of early 2011, ASA estimates there are approximately 2,000 medical cannabis dispensaries in California.

Dispensaries operate with a closed membership that allows only qualified patients and primary caregivers to obtain cannabis, and only after membership is approved (upon verification of patient documentation). Many dispensaries offer on-site consumption, providing a safe and comfortable place where patients can medicate. An increasing number of dispensaries offer additional services for their patient membership, including such services as: massage, acupuncture, legal trainings, free meals, or counseling. Research on the social benefits for patients is discussed in the last section of this report.

RATIONALE FOR MEDICAL CANNABIS DISPENSING COLLECTIVES

While the Compassionate Use Act does not explicitly discuss medical cannabis dispensaries, it calls for the federal and state governments to "implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana" (Health & Safety Code § 11362.5). This portion of the law has been the basis for the development of compassionate, community-based systems of access for patients in various parts of California. In some cases, that has meant the creation of patient-run growing collectives that allow those with cultivation expertise to help other patients obtain medicine. In most cases, particularly in urban settings, that has meant the establishment of medical cannabis dispensing collectives, or dispensaries. These dispensaries are typically organized and run by groups of patients and their caregivers in a collective model of patient-directed health care that is becoming a prototype for the delivery of other health services.

MEDICAL CANNABIS DISPENSARIES ARE LEGAL UNDER STATE LAW

In an effort to clarify the voter initiative of 1996 and aid in its implementation across the state, the California legislature passed the Medical Marijuana Program Act (MMP), or Senate Bill 420, in 2003, establishing that qualified patients and primary caregivers may collectively or cooperatively cultivate and distribute cannabis for medical purposes (Cal. Health & Safety Code section 11362.775). The Act also exempts collectives and cooperatives from criminal sanctions associated with "sales" and maintaining a place where sales occur.

In 2005, California's Third District Court of Appeal affirmed the legality of collectives and cooperatives in the landmark case of *People v. Urziceanu*, which held that the MMP provides collectives and cooperatives a defense to marijuana distribution charges. Another landmark decision from the Third District Court of Appeal in the case of *County of Butte v. Superior Court* (2009) not only affirmed the legality of collectives but also found that collective members could contribute financially without having to directly participate in the cultivation.

In August 2008, the State Attorney General issued guidelines declaring that "a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law." The Attorney General provided law enforcement with a list of operational practices for collectives to help ensure compliance with state law. By adhering to a set of rules—including not-for-profit operation, the collection of sales tax, and the verification of patient status for collective members—dispensaries can operate lawfully and maintain legitimacy. In addition, local officials can use the Attorney General guidelines to help them adopt local regulatory ordinances.

In September 2010, the California Legislature

enacted Assembly Bill 2650, which states that medical marijuana dispensaries must be located further than 600-ft from a school. By recognizing "a medical marijuana cooperative, collective, dispensary, operator, establishment, or provider that is authorized by law to possess, cultivate, or distribute medical marijuana and that has a storefront or mobile retail outlet which ordinarily requires a local business license," the Legislature has expressed its intent that storefront dispensaries and delivery services are legal under California law.

WHY PATIENTS NEED CONVENIENT DISPENSARIES

While some patients with long-term illnesses or injuries have the time, space, and skill to cultivate their own cannabis, the majority of patients, particularly those in urban settings, do not have the ability to produce it themselves. For those patients, dispensaries are the only option for safe and legal access. This is all the more true for those individuals who are suffering from a sudden, acute injury or illness.

Many of the most serious and debilitating injuries and illnesses require immediate relief. A cancer patient, for instance, who has just begun chemotherapy will typically need immediate access for help with nausea, which is why a Harvard study found that 45% of oncologists were already recommending cannabis to their patients, even before it was legal in any state. It is unreasonable to exclude those patients most in need simply because they are incapable of gardening or cannot wait months for relief.

WHAT COMMUNITIES ARE DOING TO HELP PATIENTS

Many communities in California have recognized the essential service that dispensaries provide and have either tacitly allowed their operation or adopted ordinances regulating them. Dispensary regulation is one way in which the cities can exert local control and ensure that the needs of patients and the community at large are being met. As of January 2011, 42 cities and nine counties have enacted regulations, and many more are considering doing so soon.

Officials recognize their duty to implement state laws, even in instances where they may not have previously supported medical cannabis legislation. Duke Martin, former mayor pro tem of Ridgecrest said during a city council hearing on a local dispensary ordinance, "it's something that's the law, and I will uphold the law."

This understanding of civic obligation was echoed at the Ridgecrest hearing by then-Councilmember Ron Carter, now mayor pro tem, who said, "I want to make sure everything is legitimate and above board. It's legal. It's not something we can stop, but we can have an ordinance of regulations."

Similarly, Whittier Planning Commissioner R.D. McDonnell spoke publicly of the benefits of dispensary regulations at a city government hearing. "It provides us with reasonable protections," he said. "But at the same time provides the opportunity for the legitimate operations."

Whittier officials discussed the possibility of an outright ban on dispensary operations, but Councilmember Greg Nordback said, "It was the opinion of our city attorney that you can't ban them; it's against the law. You have to come up with an area they can be in." Whittier passed its dispensary ordinance in December 2005.

Placerville Police Chief George Nielson commented that, "The issue of medical marijuana continues to be somewhat controversial in our community, as I suspect and hear it remains in other California communities. The issue of 'safe access' is important to some and not to others. There was some objection to the dispensary ordinance, but I would say it was a vocal minority on the issue."

IMPACT OF DISPENSARIES AND REGULATORY ORDINANCES ON COMMUNITIES IN CALIFORNIA

DISPENSARIES REDUCE CRIME AND IMPROVE PUBLIC SAFETY

Some reports have suggested that dispensaries are magnets for criminal activity and other undesirable behavior, which poses a problem for the community. But the experience of those cities with dispensary regulations says otherwise. Crime statistics and the accounts of local officials surveyed by ASA indicate that crime is actually reduced by the presence of a dispensary. And complaints from citizens and surrounding businesses are either negligible or are significantly reduced with the implementation of local regulations.

This trend has led multiple cities and counties to consider regulation as a solution. Kern County, which passed a dispensary ordinance in July 2006, is a case in point. The sheriff there noted in his staff report that "regulatory oversight at the local levels helps prevent crime directly and indirectly related to illegal operations occurring under the pretense and protection of state laws authorizing Medical Marijuana Dispensaries." Although dispensary-related crime has not been a problem for the county, the regulations will help law enforcement determine the legitimacy of dispensaries and their patients.

The sheriff specifically pointed out that, "existing dispensaries have not caused noticeable law enforcement problems or secondary effects for at least one year. As a result, the focus of the proposed Ordinance is narrowed to insure Dispensary compliance with the law" (Kern County Staff Report, Proposed Ordinance Regulating Medical Cannabis Dispensaries, July 11, 2006).

The presence of a dispensary in the neighborhood can actually improve public safety and reduce crime. Most dispensaries take security for their members and staff more seriously than many businesses. Security cameras are often used both inside and outside the premises, and security guards are often employed to ensure safety. Both cameras and security guards serve as a general deterrent to criminal activity and other problems on the street. Those likely to engage in such activities tend to move to a less-monitored area, thereby ensuring a safe environment not only for dispensary members and staff, but also for neighbors and businesses in the surrounding area.

Residents in areas surrounding dispensaries have reported improvements to the neighborhood. Kirk C., a long time San Francisco resident, commented at a city hearing, "I have lived in the same apartment along the Divisadero corridor in San Francisco for the past five years. Each store that has opened in my neighborhood has been nicer, with many new restaurants quickly becoming some of the city's hottest spots. My neighborhood's crime and vandalism seems to be going down year after year. It strikes me that the dispensaries have been a vital part of the improvement that is going on in my neighborhood."

Oakland city administrator Barbara Killey, who was responsible for the ordinance regulating dispensaries, noted that "The areas around the dispensaries may be some of the safest areas of Oakland now because of the level of security, surveillance, etc...since the ordinance passed."

Likewise, former Santa Rosa Mayor Jane Bender noted that since her city passed its ordinance, there appears to be "a decrease in criminal activity. There certainly has been a decrease in complaints. The city attorney says there have been no complaints either from citizens or from neighboring businesses."

Neighboring Sebastopol has had a similar experience. Despite public opposition to medical cannabis dispensaries, Sebastopol Police Chief Jeffrey Weaver admitted that for more than two years, "We've had no increased crime associated [with Sebastopol's medical cannabis dispensary], no fights, no loitering, no increase in graffiti, no increase in littering, zip."

"The parade of horrors that everyone predicted has not materialized. The sky has not fallen. To the contrary…California jurisdictions have shown that having medical cannabis in place does not impact…public safety." —San Francisco Supervisor David Campos

Those dispensaries that go through the permitting process or otherwise comply with local ordinances tend, by their very nature, to be those most interested in meeting community standards and being good neighbors. Many local officials surveyed by ASA said dispensaries operating in their communities have presented no problems, or what problems there may have been significantly diminished once an ordinance or other regulation was instituted.

Several officials said that regulatory ordinances had significantly improved relations with other businesses and the community at large. An Oakland city council staff member noted that prior to adopting a local ordinance, the city had received reports of break-ins. However, the council staff member said that with the adoption of Oakland's dispensary ordinance, "That kind of activity has stopped. That danger has been eliminated." Assistant City Administrator Arturo Sanchez, a nuisance enforcement officer, affirmed that since 2004 he has "never received a nuisance complaint concerning lawfully established medical marijuana dispensaries in Oakland…[or] had to initiate an enforcement action."

The absence of any connection between dispensaries and increased local crime can be seen in data from Los Angeles and San Diego. During the two-year period from 2008 to 2010 in which Los Angeles saw the proliferation of more than 500 dispensaries, the overall crime rate in the city dropped considerably. A study commissioned by Los Angeles Police Chief Charlie Beck, comparing the number of crimes in 2009 at the city's banks and medical marijuana dispensaries, found that 71 robberies had occurred at the more than 350 banks in the city, compared to 47 robberies at the more than 500 medical marijuana facilities. Chief Beck observed that, "banks are more likely to get robbed than medical marijuana dispensaries," and that the claim that dispensaries attract crime "doesn't really bear out." In San Diego, where some officials have made similar allegations about increased crime associated with dispensaries, an examination of city police reports by a local paper, the San Diego CityBeat, found that as of late 2009 the number of crimes in areas with dispensaries was frequently lower than it was before the dispensary opened or, at worst, stayed the same.

WHY DIVERSION OF MEDICAL CANNABIS IS TYPICALLY NOT A PROBLEM

One of the concerns of public officials is that dispensaries make possible or even encourage the resale of cannabis on the street. But the experience of those cities that have instituted ordinances is that such problems, which are rare in the first place, quickly disappear. In addition to being monitored by law enforcement, dispensaries universally have strict rules about how members are to behave in and around the facility. Many have "good neighbor" trainings for their members that emphasize sensitivity to the concerns of neighbors, and all dispensaries absolutely prohibit the resale of cannabis. Anyone violating that prohibition is typically banned from any further contact with the dispensary.

As Oakland's city administrator for the regulatory ordinance explains, "dispensaries themselves have been very good at self policing

against resale because they understand they can lose their permit if their patients resell."

In the event of an illegal resale, local law enforcement has at its disposal all of the many legal penalties provided by the state. This all adds up to a safer street environment with fewer drug-related problems than before dispensary operations were permitted in the area. The experience of the City of Oakland is a good example of this phenomenon. The city's legislative analyst, Lupe Schoenberger, stated that, "...[P]eople feel safer when they're walking down the street. The level of marijuana street sales has significantly reduced."

> "The areas around the dispensaries may be some of the most safest areas of Oakland now because of the level of security, surveillance, etc. since the ordinance passed."
> —Barbara Killey, Oakland

Dispensaries operating with the permission of the city are also more likely to appropriately utilize law enforcement resources themselves, reporting any crimes directly to the appropriate agencies. And dispensary operators and their patient members tend to be more safety conscious than the general public, resulting in greater vigilance and better preemptive measures. The reduction of crime in areas around dispensaries has been reported anecdotally by law enforcement in several communities.

DISPENSARIES CAN BE GOOD NEIGHBORS

Medical cannabis dispensing collectives are typically positive additions to the neighborhoods in which they locate, bringing additional customers to neighboring businesses and reducing crime in the immediate area.

Like any new business that serves a different customer base than the existing businesses in the area, dispensaries increase the revenue of other businesses in the surrounding area simply because new people are coming to access services, increasing foot traffic past other establishments. In many communities, the opening of a dispensary has helped revitalize an area. While patients tend to opt for dispensaries that are close and convenient, particularly since travel can be difficult, many patients will travel to dispensary locations in parts of town they would not otherwise visit. Even if patients are not immediately utilizing the services or purchasing the goods offered by neighboring businesses, they are more likely to eventually patronize those businesses because of convenience.

ASA's survey of officials whose cities have passed dispensary regulations found that the vast majority of businesses either adjoining or near dispensaries had reported no problems associated with a dispensary opening after the implementation of regulations.

Kriss Worthington, longtime councilmember in Berkeley, said in support of a dispensary there, "They have been a responsible neighbor and vital organization to our diverse community. Since their opening, they have done an outstanding job keeping the building clean, neat, organized and safe. In fact, we have had no calls from neighbors complaining about them, which is a sign of respect from the community. In Berkeley, even average restaurants and stores have complaints from neighbors."

Mike Rotkin, councilmember and former mayor of the City of Santa Cruz, said about the dispensary that opened there last year, "The immediately neighboring businesses have been uniformly supportive or neutral. There have been no complaints either about establishing it or running it."

And Dave Turner, mayor of Fort Bragg, noted that before the passage of regulations there were "plenty of complaints from both neighboring businesses and concerned citizens," but since then, it is no longer a problem. Public officials understand that, when it comes to dispensaries, they must balance both the humanitarian needs of patients and the

concerns of the public, especially those of neighboring residents and business owners.

Oakland City Councilmember Nancy J. Nadel wrote in an open letter to her fellow colleagues across the state, "Local government has a responsibility to the medical needs of its people, even when it's not a politically easy choice to make. We have found it possible to build regulations that address the concerns of neighbors, local businesses, law enforcement and the general public, while not compromising the needs of the patients themselves. We've found that by working with all interested parities in advance of adopting an ordinance while keeping the patients' needs foremost, problems that may seem inevitable never arise."

Mike Rotkin of Santa Cruz stated that since the city enacted an ordinance for dispensaries, "Things have calmed down. The police are happy with the ordinance, and that has made things a lot easier. I think the fact that we took the time to give people who wrote us respectful and detailed explanations of what we were doing and why made a real difference."

BENEFITS OF DISPENSARIES TO THE PATIENT COMMUNITY

DISPENSARIES PROVIDE MANY BENEFITS TO THE SICK AND SUFFERING

Safe and legal access to cannabis is the reason dispensaries have been created by patients and caregivers around the state. For many people, dispensaries remove significant barriers to obtaining cannabis. Patients in urban areas with no space to cultivate cannabis, those without the requisite gardening skills to grow their own, and, most critically, those who face the sudden onset of a serious illness or who have suffered a catastrophic illness—all tend to rely on dispensaries as a compassionate, community-based solution as a preferable alternative to potentially dangerous illicit market transactions.

Many elected officials in California recognize the importance of dispensaries to their constituents. As Nathan Miley, former Oakland city councilmember and now Alameda County supervisor said in a letter to his colleagues, "When designing regulations, it is crucial to remember that at its core this is a healthcare issue, requiring the involvement and leadership of local departments of public health. A pro-active healthcare-based approach can effectively address problems before they arise, and communities can design methods for safe, legal access to medical marijuana while keeping the patients' needs foremost."

West Hollywood Mayor John Duran agreed, noting that with the high number of HIV-positive residents in the area, "Some of them require medical marijuana to offset the medications they take for HIV."

Jane Bender, former mayor of Santa Rosa, says, "There are legitimate patients in our community, and I'm glad they have a safe means of obtaining their medicine."

And Mike Rotkin of Santa Cruz said that this is also an important matter for his city's citizens: "The council considers it a high priority and has taken considerable heat to speak out and act on the issue."

It was a similar decision of social conscience

that lead to Placerville's city council putting a regulatory ordinance in place. Former Councilmember Marian Washburn told her colleagues that "as you get older, you know people with diseases who suffer terribly, so that is probably what I get down to after considering all the other components."

"There are legitimate patients in our community, and I'm glad they have a safe means of obtaining their medicine." —Jane Bender, Santa Rosa

While dispensaries provide a unique way for patients to obtain the cannabis their doctors have recommended, they typically offer far more that is of benefit to the health and welfare of those suffering from both chronic and acute medical problems.

Dispensaries are often called "clubs" in part because many of them offer far more than a clinical setting for obtaining cannabis. Recognizing the isolation that many seriously ill and injured people experience, many dispensary operators choose to offer a wider array of social services, including everything from a place to congregate and socialize to help with finding housing and offering meals. The social support patients receive in these settings has far-reaching benefits that also influences the development of other patient-based care models.

RESEARCH SUPPORTS THE DISPENSARY MODEL

A 2006 study by Amanda Reiman, Ph.D. of the School of Social Welfare at the University of California, Berkeley examined the experience of 130 patients spread among seven different dispensaries in the San Francisco Bay Area. Dr. Reiman's study cataloged the patients' demographic information, health status, consumer satisfaction, and use of services, while also considering the dispensaries' environment, staff, and services offered. The study found that "medical cannabis patients have created a system of dispensing medical cannabis that also includes services such as counseling, entertainment and support groups, all important components of coping with chronic illness." She also found that levels of satisfaction with the care received at dispensaries ranked significantly higher than those reported for health care nationally.

Patients who use the dispensaries studied uniformly reported being well satisfied with the services they received, giving an 80% satisfaction rating. The most important factors for patients in choosing a medical cannabis dispensary were: feeling comfortable and secure, familiarity with the dispensary, and having a rapport with the staff. In their comments, patients tended to note the helpfulness and kindness of staff and the support found in the presence of other patients.

MANY DISPENSARIES PROVIDE KEY HEALTH AND SOCIAL SERVICES

Dispensaries offer many cannabis-related services that patients cannot otherwise obtain. Among them is an array of cannabis varieties, some of which are more useful for certain afflictions than others, and staff awareness of what types of cannabis other patients report to be helpful. In other words, one variety of cannabis may be effective for pain control while another may be better for combating nausea. Dispensaries allow for the pooling of information about these differences and the opportunity to access the type of cannabis likely to be most beneficial.

Cannabis-related services include making cannabis available in other forms for patients who cannot or do not want to smoke it. While most patients prefer to have the ability to modulate the dosing that smoking easily allows, for others, the effects of extracts or edible cannabis products are preferable. Dispensaries typically offer a wide array of edible products for those purposes. Many dispensaries also offer classes on how to grow your own

cannabis, classes on legal matters, trainings for health-care advocacy, and other seminars.

Beyond providing safe and legal access to cannabis, the dispensaries studied also offer important social services to patients, including counseling, help with housing and meals, hospice and other care referrals. Among the broader services the study found in dispensaries are support groups, including groups for women, veterans, and men; creativity and art groups, including groups for writers, quilters, crochet, and crafts; and entertainment options, including bingo, open mic nights, poetry readings, internet access, libraries, and puzzles. Clothing drives and neighborhood parties are among the activities that patients can also participate in through their dispensary.

Examples of health services offered at dispensaries across California:

- Naturopathic medicine
- Reiki
- Ayurvedic medicine
- Chinese medicine
- Chiropractic medicine
- Acupuncture
- Massage
- Craniosacral Therapy
- Rolfing Therapy
- Group & Individual Yoga Instruction
- Hypnotherapy
- Homeopathy
- Western Herbalists
- Individual Counseling
- Integrative Health Counseling
- Nutrition & Diet Counseling
- Limited Physical Therapy
- Medication Interaction Counseling
- Condition-based Support Groups

Social services such as counseling and support groups were reported to be the most commonly and regularly used, with two-thirds of patients reporting that they use social services at dispensaries one to two times per week. Additionally, life services such as free food and housing help were used at least once or twice a week by 22% of those surveyed.

"Local government has a responsibility to the medical needs of its people, even when it's not a politically easy choice to make. We have found it possible to build regulations that address the concerns of neighbors, local businesses law enforcement and the general public, while not compromising the needs of the patients themselves. We've found that by working with all interested parties in advance of adopting an ordinance, while keeping the patients' needs foremost, problems that may seem inevitable never arise."

—Nancy Nadel, Oakland

Dispensaries offer chronically ill patients even more than safe and legal access to cannabis and an array of social services. The study found that dispensaries also provided other social benefits for the chronically ill, an important part of the bigger picture:

> Beyond the support that medical cannabis patients receive from services is the support received from fellow patients, some of whom are experiencing the same or similar physical/psychological symptoms… It is possible that the mental health benefits derived from the social support of fellow patients is an important part of the healing process, separate from the medicinal value of the cannabis itself.

Several researchers and physicians who have studied the issue of the patient experience with dispensaries have concluded that there are other important positive effects stemming from a dispensary model that includes a component of social support groups.

Dr. Reiman notes that, "support groups may have the ability to address issues besides the illness itself that might contribute to long-term physical and emotional health outcomes,

such as the prevalence of depression among the chronically ill."

For those who suffer the most serious illnesses, such as HIV/AIDS and terminal cancer, groups of people with similar conditions can also help fellow patients through the grieving process. Many patients who have lost or are losing friends and partners to terminal illness report finding solace with other patients who are also grieving or facing end-of-life decisions. A medical study published in 1998 concluded that the patient-to-patient contact associated with the social club model was the best therapeutic setting for ill people.

Cannabis dispensaries have been operating successfully in California for more than 14

CONCLUSION

After more than 14 years of existence, dispensaries are proving to be an asset to the communities they serve, as well as the larger community in which they operate. This is especially the case when public officials choose to implement local ordinances that recognize the lawful operation of dispensaries. Since the Medical Marijuana Program Act was enacted by the California legislature in 2004, more than 50 localities have adopted ordinances regulating dispensaries.

By surveying local officials and monitoring regulatory activity throughout the State of California, ASA has shown that once working regulatory ordinances are in place, dispensaries are typically viewed favorably by public officials, neighbors, businesses, and the community at large, and that regulatory ordinances can and do improve an area, both socially and economically.

Dispensaries—now expressly legal under California state law—are helping revitalize neighborhoods by reducing crime and bringing new customers to surrounding businesses. They improve public safety by increasing the security presence in neighborhoods, reducing illicit market marijuana sales, and ensuring that any criminal activity gets reported to the appropriate law enforcement authorities.

More importantly, dispensaries benefit the community by providing safe access for those who have the greatest difficulty getting the medicine their doctors recommend: the most seriously ill and injured. Many dispensaries also offer essential services to patients, such as help with food and housing.

Medical and public health studies have also shown that the social-club model of most dispensaries is of significant benefit to the overall health of patients. The result is that medical cannabis patients rate their satisfaction with dispensaries as far greater than the customer satisfaction ratings given to health care agencies in general.

Public officials across the state, in both urban and rural communities, have been outspoken in praise of the dispensary regulatory schemes they enacted and the benefits to the patients and others living in their communities.

As a compassionate, community-based response to the medical needs of more than 300,000 sick and suffering Californians, dispensaries, and the regulations under which they operate, are working.

RECOMMENDATIONS FOR DISPENSARY REGULATIONS

years with very few problems. And, although the legislature and courts have acted to make dispensaries legal under state law, the question of how to implement appropriate zoning laws and business licensing is still coming before local officials all across the state. What follows are recommendations on matters to consider, based on adopted code as well as ASA's extensive experience working with community leaders and elected officials.

COMMUNITY OVERSIGHT

In order to appropriately resolve conflict in the community and establish a process by which complaints and concerns can be reviewed, it can often be helpful to create a community oversight committee. Such committees, if fair and balanced, can provide a means for the voices of all affected parties to be heard, and to quickly resolve problems.

The Ukiah City Council created such a task force in 2005; what follows is how they defined the group:

> The Ukiah Medical Marijuana Review and Oversight Commission shall consist of seven members nominated and appointed pursuant to this section. The Mayor shall nominate three members to the commission, and the City Council shall appoint, by motion, four other members to the commission...
>
> Of the three members nominated by the Mayor, the Mayor shall nominate one member to represent the interests of City neighborhood associations or groups, one member to represent the interests of medical marijuana patients, and one member to represent the interests of the law enforcement community.
>
> Of the four members of the commission appointed by the City Council, two members shall represent the interests of City neighborhood associations or groups, one member shall represent the interests of the medical marijuana community, and one member shall represent the interests of the public health community.

ADMINISTRATION OF DISPENSARY REGULATIONS ARE BEST HANDLED BY HEALTH OR PLANNING DEPARTMENTS, NOT LAW ENFORCEMENT AGENCIES

Reason: To ensure that qualified patients, caregivers, and dispensaries are protected, general regulatory oversight duties—including permitting, record maintenance, and related protocols—should be the responsibility of the local department of public health (DPH) or planning department. Given the statutory mission and responsibilities of DPH, it is the natural choice and best-suited agency to address the regulation of medical cannabis dispensing collectives. Law enforcement agencies are ill-suited for handling such matters, having little or no expertise in health and medical affairs.

Examples of responsible agencies and officials:

- Angels Camp—City Administrator
- Citrus Heights—City Manager
- Cotati—City Manager
- Dunsmuir—Planning Commission
- Eureka–Dept of Community Development
- Laguna Woods—City Manager
- Long Beach—Financial Management
- Los Angeles—Building and Safety
- Malibu—City Manager
- Napa—City Council
- Palm Springs—City Manager

- Plymouth—City Administrator
- Sebastopol—Planning Department
- San Francisco—Dept. of Public Health
- San Mateo—License Committee
- Santa Barbara—Community Development
- Selma—City Manager
- Stockton—City Manager
- Visalia—City Planner

ARBITRARY CAPS ON THE NUMBER OF DISPENSARIES CAN BE COUNTER-PRODUCTIVE

Reason: Policymakers do not need to set arbitrary limitations on the number of dispensing collectives allowed to operate because, as with other services, competitive market forces and consumer choice will be decisive. Dispensaries that provide quality care and patient services to their memberships will flourish, while those that do not will fail.

Capping the number of dispensaries limits consumer choice, which can result in both decreased quality of care and less affordable medicine. Limiting the number of dispensing collectives allowed to operate may also force patients with limited mobility to travel farther for access than they would otherwise need to.

Artificially limiting the supply for patients can result in an inability to meet demand, which in turn may lead to unintended and undesirable effects such as lines outside of dispensaries, increased prices, and lower quality medicine, in addition to increased illicit-market activity.

Examples of cities and counties without numerical caps on dispensaries:

- Dunsmuir
- Fort Bragg
- Laguna Woods
- Long Beach
- Placerville
- Redding
- Ripon
- San Mateo
- Santa Barbara
- Selma
- Tulare
- Calaveras County
- Kern County
- City and County of San Francisco
- San Mateo County
- Sonoma County

RESTRICTIONS ON WHERE DISPENSARIES CAN LOCATE ARE OFTEN UNNECESSARY AND CAN CREATE BARRIERS TO ACCESS

Reason: As described in this report, regulated dispensaries do not generally increase crime or bring other harm to their neighborhoods, regardless of where they are located. And since travel is difficult for many patients, cities and counties should take care to avoid unnecessary restrictions on where dispensaries can locate. Patients benefit from dispensaries being convenient and accessible, especially if the patients are disabled or have conditions that limit their mobility.

It is unnecessary and burdensome for patients and providers to restrict dispensaries to industrial corners, far away from public transit and other services. Depending on a city's population density, it can also be extremely detrimental to set excessive proximity restrictions (to residences, schools or other facilities) that can make it impossible for dispensaries to locate anywhere within the city limits, thereby establishing a de facto ban on dispensing. It is important to balance patient needs with neighborhood concerns in this process.

PATIENTS BENEFIT FROM ON-SITE CONSUMPTION AND PROPER VENTILATION SYSTEMS

Reason: Dispensaries that allow members to consume medicine on-site have positive psychosocial health benefits for chronically ill people who are otherwise isolated. On-site consumption encourages dispensary members to take advantage of the support services that can improve their quality of life and, in some cases, even prolong it. Researchers have shown that support groups like those offered by dispensaries are effective for patients with a variety of serious illnesses. Participants active

in support services are less anxious and depressed, make better use of their time, and are more likely to return to work than patients who receive only standardized care, regardless of whether they have serious psychiatric symptoms. On-site consumption is also important for patients who face restrictions to off-site consumption, such as those in subsidized or other housing arrangements that prohibit smoking. In addition, on-site consumption provides an opportunity for patients to share information about effective use of cannabis and of specialized delivery methods, such as vaporizers, which do not require smoking.

Examples of localities that permit on-site consumption (many stipulate ventilation requirements):

- Alameda County
- Berkeley
- Kern County
- Laguna Woods
- Richmond
- San Francisco
- San Mateo County
- South El Monte

DIFFERENTIATING DISPENSARIES FROM PRIVATE PATIENT COLLECTIVES IS IMPORTANT

Reason: Private patient collectives, in which several patients grow their medicine collectively at a private location, should not be required to follow the same restrictions that are placed on retail dispensaries, since they are a different type of operation. A too-broadly written ordinance may inadvertently put untenable restrictions on individual patients and caregivers who are providing either for themselves or a few others.

Example: Santa Rosa's adopted ordinance, provision 10-40.030 (F):

> "Medical cannabis dispensing collective," hereinafter "dispensary," shall be construed to include any association, cooperative, affiliation, or collective of persons where multiple "qualified patients" and/or "primary care givers," are organized to provide education, referral, or network services, and facilitation or assistance in the lawful, "retail" distribution of medical cannabis. "Dispensary" means any facility or location where the primary purpose is to dispense medical cannabis (i.e., marijuana) as a medication that has been recommended by a physician and where medical cannabis is made available to and/or distributed by or to two or more of the following: a primary caregiver and/or a qualified patient, in strict accordance with California Health and Safety Code Section 11362.5 et seq. A "dispensary" shall not include dispensing by primary caregivers to qualified patients in the following locations and uses, as long as the location of such uses are otherwise regulated by this Code or applicable law: a clinic licensed pursuant to Chapter 1 of Division 2 of the Health and Safety Code, a health care facility licensed pursuant to Chapter 2 of Division 2 of the Health and Safety Code, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 of Division 2 of the Health and Safety Code, residential care facility for the elderly licensed pursuant to Chapter 3.2 of Division 2 of the Health and Safety Code, a residential hospice, or a home health agency licensed pursuant to Chapter 8 of Division 2 of the Health and Safety Code, as long as any such use complies strictly with applicable law including, but not limited to, Health and Safety Code Section 11362.5 et seq., or a qualified patient's or caregiver's place of residence.

PATIENTS BENEFIT FROM ACCESS TO EDIBLES AND MEDICAL CANNABIS CONSUMPTION DEVICES

Reason: Not all patients can or want to smoke cannabis. Many find tinctures (cannabis extracts) or edibles (such as baked goods containing cannabis) to be more effective for their conditions. Allowing dispensaries to

carry these items is vital to patients getting the best level of care possible. For patients who have existing respiration problems or who otherwise have an aversion to smoking, edibles and extracts are essential.

Conversely, for patients who do choose to smoke or vaporize, they need to procure the tools to do so. Prohibiting dispensaries from carrying medical cannabis consumption devices, often referred to as paraphernalia, forces patients to go elsewhere to procure these items. Additionally, when dispensaries do carry these devices, informed dispensary staff can explain their usage, and different functions, to new patients.

Examples of localities allowing dispensaries to carry edibles and delivery devices:

- Albany
- Angels Camp
- Berkeley
- Cotati
- Citrus Heights
- Eureka
- Laguna Woods
- Long Beach
- Los Angeles (city of)
- Malibu
- Napa
- Palm Springs
- Redding
- Richmond
- Santa Barbara
- Santa Cruz
- Sebastopol
- South El Monte
- Stockton
- Sutter Creek
- West Hollywood
- Alameda County
- Kern County
- Sonoma County

RESOURCES FOR MORE INFORMATION

A downloadable PDF of this report is online at AmericansForSafeAccess.org/DispensaryReport

A model dispensary ordinance can be seen at AmericansForSafeAccess.org/ModelOrdinance.

A regularly updated list of ordinances, moratoriums, and bans adopted by California cities and counties can be found at AmericansForSafeAccess.org/regulations.

You can find ASA chapters in your area at AmericansForSafeAccess.org/Chapters.

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Contact ASA to order the DVD "Medical Cannabis in California"—interviews with elected officials and leaders who are implementing safe and effective regulations.

APPENDIX A

CALIFORNIA CITIES AND COUNTIES THAT HAVE ADOPTED ORDINANCES REGULATING DISPENSARIES

(as of February 2011)

For an updated list, go to:
AmericansForSafeAccess.org/regulations

City Ordinances (42)

Albany
Angels Camp
Berkeley
Citrus Heights
Cotati
Diamond Bar
Dunsmuir
Eureka
Fort Bragg
Jackson
La Puente
Laguna Woods
Long Beach
Los Angeles
Malibu
Mammoth Lakes
Martinez
Napa
Oakland
Palm Springs
Placerville
Plymouth
Redding
Richmond
Ripon
Sacramento
San Carlos
San Francisco
San Jose
San Mateo
Santa Barbara
Santa Cruz
Santa Rosa
Sebastopol
Selma
South El Monte
Stockton
Tulare
Visalia
West Hollywood
Whittier
Yucca Valley

County Ordinances (9)

Alameda
Calaveras
Kern
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Sonoma

APPENDIX B

ASA'S QUICK GUIDE FOR EVALUATING PROPOSED MEDICAL MARIJUANA DISPENSARY ORDINANCES IN CALIFORNIA

This is a quick guide to what should and should not be in city and county ordinances to best support safe access for medical cannabis patients.

What the ordinance MUST include:

- Allowance for over-the-counter/storefront sales (sometimes called reimbursements, contributions, or not-for-profit sales)
- Allowance for patients to medicate on-site
- Allowance for sale of cannabis edibles and concentrated extracts
- Distinction between Medical Cannabis Dispensing Collectives (MCDCs) and private patient collectives or cooperatives

What to look out for in proposed ordinances:

Is the general language and focus framed as a medical or healthcare issue, rather than a criminal justice or law enforcement problem?

Does the ordinance affirm that MCDCs should be organized to serve patients and have a "not-for-profit" business model?

Is there a cap on the number of MCDCs allowed to operate that could negatively impact accessibility, affordability and quality?

- How was the MCDC cap number determined (per capita, per pharmacy)?
- What criteria will be used to approve and license MCDCs?
- Will quality through competition be supported?

Zoning considerations:

- Will each MCDC be required to apply for a conditional use permit, or does the ordinance specify MCDCs as an enumerated business?
- Are there proximity restrictions or "buffer zones" from so-called "sensitive uses" which will make locating a dispensary onerous?
- Has a map been prepared that shows where the ordinance will require MCDCs to locate?

Does the ordinance provide for a community oversight committee tasked with any licensing or appeals processes?

- Will the oversight committee include patients, activists, MCDC operators, and members of the local community?

What are the MCDC requirements for book-keeping and records disclosure?

- Does the ordinance allow MCDCs to keep identifying information about its members off-site, to protect patient identities?
- Does law enforcement have unfettered access to patient records or is a subpoena required?

Are there caps on the number of patient-members an MCDC can serve?

Is on-site cultivation prohibited for MCDCs?

APPENDIX C

ATTORNEY GENERAL, STATE OF CALIFORNIA, GUIDELINES FOR THE SECURITY AND NON-DIVERSION OF MARIJUANA GROWN FOR MEDICAL USE

August 2008

GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

Under California law, medical marijuana patients and primary caregivers may "associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes" (§ 11362.775) .The following guidelines are meant to apply to qualified patients and primary caregivers who come together to collectively or cooperatively cultivate physician-recommended marijuana.

A. **Business Forms**: Any group that is collectively or cooperatively cultivating and distributing marijuana for medical purposes should be organized and operated in a manner that ensures the security of the crop and safeguards against diversion for non-medical purposes. The following are guidelines to help cooperatives and collectives operate within the law, and to help law enforcement determine whether they are doing so.

1. **Statutory Cooperatives**: A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members (Corp. Code, § 12201, 12300). No business may call itself a "cooperative" (or "coop") unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code (Id. at § 12311(b)). Cooperative corporations are "democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons" (Id. at § 12201). The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (Ibid.) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year (id. at § 12200, et seq). Agricultural cooperatives are likewise nonprofit corporate entities "since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers" (Food & Agric. Code, § 54033). Agricultural cooperatives share many characteristics with consumer cooperatives (e.g., id. at § 54002, et seq). Cooperatives should not purchase marijuana from, or sell to, nonmembers; instead, they should only provide a means for facilitating or coordinating transactions between members.

2. **Collectives**: California law does not define collectives, but they are commonly defined as "a business, farm, etc., jointly owned and operated by the members of a group." Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members—including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions among members.

B. **Guidelines for the Lawful Operation of a Cooperative or Collective**: Collectives and cooperatives should be organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws. The following are some suggested guidelines and practices for operating collective growing

operations to help ensure lawful operation. 1. Non-Profit Operation: Nothing in Proposition 215 or the MMP authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana. (See, e.g., § 11362.765(a) ["nothing in this section shall authorize . . . any individual or group to cultivate or distribute marijuana for profit"].

2. **Business Licenses, Sales Tax, and Sellers' Permits**: The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller's Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.

3. **Membership Application and Verification**: When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:

a) Verify the individual's status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician's identity, as well as his or her state licensing status. Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient's recommendation. Copies should be made of the physician's recommendation or identification card, if any;
b) Have the individual agree not to distribute marijuana to non-members;
c) Have the individual agree not to use the marijuana for other than medical purposes;
d) Maintain membership records on-site or have them reasonably available;
e) Track when members' medical marijuana recommendation and/or identification cards expire; and
f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are invalid or have expired, or who are caught diverting marijuana for non-medical use.

4. **Collectives Should Acquire, Possess, and Distribute Only Lawfully Cultivated Marijuana**: Collectives and cooperatives should acquire marijuana only from their constituent members, because only marijuana grown by a qualified patient or his or her primary caregiver may lawfully be transported by, or distributed to, other members of a collective or cooperative (§§ 11362.765, 11362.775). The collective or cooperative may then allocate it to other members of the group. Nothing allows marijuana to be purchased from outside the collective or cooperative for distribution to its members. Instead, the cycle should be a closed circuit of marijuana cultivation and consumption with no purchases or sales to or from non-members. To help prevent diversion of medical marijuana to nonmedical markets, collectives and cooperatives should document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana.

5. **Distribution and Sales to Non-Members are Prohibited**: State law allows primary caregivers to be reimbursed for certain services (including marijuana cultivation), but nothing allows individuals or groups to sell or distribute marijuana to non-members. Accordingly, a collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization. A dispensing collective or cooperative may credit its members for marijuana they provide to the collective, which it may then allocate to other members (§ 11362.765(c)). Members also may reimburse the collective or cooperative for marijuana that has been allocated to them. Any monetary reimbursement that members provide to the collective or cooperative should only be an amount necessary to cover overhead costs and operating expenses.

6. **Permissible Reimbursements and Allocations**: Marijuana grown at a collective or cooperative for medical purposes may be:

a) Provided free to qualified patients and

primary caregivers who are members of the collective or cooperative;
b) Provided in exchange for services rendered to the entity;
c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; or d) Any combination of the above.

7. **Possession and Cultivation Guidelines**: If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits for each patient. For example, applying the MMP's basic possession guidelines, if a caregiver is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to its membership numbers. Any patient or primary caregiver exceeding individual possession guidelines should have supporting records readily available when:

a) Operating a location for cultivation;
b) Transporting the group's medical marijuana; and
c) Operating a location for distribution to members of the collective or cooperative.

8. **Security**: Collectives and cooperatives should provide adequate security to ensure that patients are safe and that the surrounding homes or businesses are not negatively impacted by nuisance activity such as loitering or crime. Further, to maintain security, prevent fraud, and deter robberies, collectives and cooperatives should keep accurate records and follow accepted cash handling practices, including regular bank runs and cash drops, and maintain a general ledger of cash transactions.

C. **Enforcement Guidelines**: Depending upon the facts and circumstances, deviations from the guidelines outlined above, or other indicia that marijuana is not for medical use, may give rise to probable cause for arrest and seizure. The following are additional guidelines to help identify medical marijuana collectives and cooperatives that are operating outside of state law.

1. **Storefront Dispensaries**: Although medical marijuana "dispensaries" have been operating in California for years, dispensaries, as such, are not recognized under the law. As noted above, the only recognized group entities are cooperatives and collectives (§ 11362.775). It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines set forth in sections IV(A) and (B), above, are likely operating outside the protections of Proposition 215 and the MMP, and that the individuals operating such entities may be subject to arrest and criminal prosecution under California law. For example, dispensaries that merely require patients to complete a form summarily designating the business owner as their primary caregiver—and then offering marijuana in exchange for cash "donations" - are likely unlawful (*Peron*, supra, 59 Cal.App.4th at p. 1400 [cannabis club owner was not the primary caregiver to thousands of patients where he did not consistently assume responsibility for their housing, health, or safety]).

2. **Indicia of Unlawful Operation**: When investigating collectives or cooperatives, law enforcement officers should be alert for signs of mass production or illegal sales, including (a) excessive amounts of marijuana, (b) excessive amounts of cash, (c) failure to follow local and state laws applicable to similar businesses, such as maintenance of any required licenses and payment of any required taxes, including sales taxes, (d) weapons, (e) illicit drugs, (f) purchases from, or sales or distribution to, non-members, or (g) distribution outside of California.

APPENDIX D — MODEL ORDINANCE

MODEL ORDINANCE FOR COLLECTIVES

WHEREAS voters approved Proposition 215 in 1996 to ensure that seriously ill Californians have the right to obtain and use cannabis for medical purposes and to encourage elected officials to implement a plan for the safe and affordable distribution of medicine; and

WHEREAS the California State Legislature adopted Senate Bill 420, the Medical Marijuana Program Act, in 2003 to help clarify and further implement Proposition 215 in part by authorizing qualified patients and primary caregivers to associate within the State of California in order to collectively or cooperatively cultivate cannabis for medical purposes; and

WHEREAS the California Attorney General published "Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Purposes" in 2008, acknowledging that "a properly organized and operated collective of cooperative that dispenses medical marijuana through a storefront may be lawful under California law," provided the facility substantially complies with state law; and

WHEREAS crime statistics and the accounts of local officials surveyed by Americans for Safe Access indicate that crime is actually reduced by the presence of a Medical Cannabis Dispensing Collective (MCDC); and complaints from citizens and surrounding businesses are either negligible or are significantly reduced with the implementation of sensible regulations; and

WHEREAS California courts have upheld the legality of MCDCs under state law, including *People v. Hochanadel*, 98 Cal.Rptr.3d 347, and *People v. Urziceanu*, 132 Cal.App.4th 747;

THEREFORE, BE IT RESOLVED That _____ does hereby enact the following:

Purposes and Intent

(1) To implement the provisions of California Health and Safety Code Sections 11362.5 and 11362.7, et seq., as described by the California Attorney General in "Guidelines For The Security And Non-diversion Of Marijuana Grown For Medical Use," published August 2008, which states in Section IV(C)(1) that "a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law," provided the facility substantially complies with the guidelines.

(2) To help ensure that seriously ill _____ residents can obtain and use cannabis for medical purposes where that medical use has been deemed appropriate by a physician in accordance with California law.

(3) To help ensure that the qualified patients and their primary caregivers who obtain or cultivate cannabis solely for the qualified patient's medical treatment are not subject to arrest, criminal prosecution, or sanction.

(4) To protect citizens from the adverse impacts of unregulated medical cannabis distribution, storage, and use practices.

(5) To establish a new section in the _____ code pertaining to the permitted distribution of medical cannabis in _____ consistent with state law.

Nothing in this ordinance purports to permit activities that are otherwise illegal under state or local law.

Definitions

The following phrases, when used in this Chapter, shall be construed as defined in California Health and Safety Code Sections 11362.5 and 11362.7:

"Person with an identification card;"
"Identification card;"
'Primary caregiver;" and
"Qualified patient."

The following phrases, when used in this Chapter, shall be construed as defined below:

"Medical Cannabis Dispensing Collective" or "MCDC". Qualified p atients, persons with identification cards and designated primary caregivers of qualified patients and persons with identification cards who associate, as an incorporated or unincorporated association, within _____, in order to collectively or cooperatively provide medical marijuana from a licensed or permitted location pursuant to this Chapter, for use exclusively by their registered members, in strict accordance with California Health and Safety Code Sections 11362.5 and 11362.7, et seq.

"Director." The Director of Planning or other person authorized to issue a Conditional Use Permit pursuant to _____ code.

Cities and counties may issue a business license or a Conditional Use Permit (CUP) to regulate MCDCs. If a jurisdiction opts for a business license model, the language in the following sections may be replaced with language authorizing the issuance of a business license by amending the appropriate code Sections: Conditional Use Permit Required, Application Procedures, and Findings.

Conditional Use Permit Required

A Conditional Use Permit shall be required to establish or operate a Medical Cannabis Dispensing Collective (MCDC) in compliance with the requirements of this Chapter when located in Commercial, Manufacturing, or Retail Zones.

Application Procedure

(1) In addition to ensuring compliance with the application procedures specified in Section _____, the Director shall send copy of the application and related materials to all other relevant City departments for their review and comment.

(2) A disclaimer shall be put on the MCDC zoning application forms that shall include the following:

a. A warning that the MCDC operators and their employees may be subject to prosecution under federal law; and

b. A disclaimer that the City will not accept any legal liability in the connection with any approval and/or subsequent operation of an MCDC.

Findings

In addition to the findings required to establish compliance with the provisions of Section _____, approval of a Conditional Use Permit for an MCDC shall require the following findings:

(1) That the requested use at the proposed location will not adversely affect the economic welfare of the community in which it is located;

(2) That the requested use at the proposed location is outside a Residential Zone;

(3) That the exterior appearance of the structure will be consistent with the exterior appearance of structures already constructed or under construction within the immediate neighborhood, so as to prevent blight or deterioration, or substantial diminishment or impairment of property values within the neighborhood.

Location

The location at which an MCDC distributes medical cannabis must meet the following requirements:

(1) The location must be in a Non-Residential Zone appropriate for Commercial, Manufacturing, or Retail uses, including health care use;

(2) The location must not be within a 600-foot radius of a school, as measured in Section 11362.768 of the California Health and Safety Code;

(3) The location must not be within 1,000 feet of another MCDC.

Police Department Procedures and Training

(1) Within six months of the date that this Chapter becomes effective, the training materials, handbooks, and printed procedures of the Police Department shall be updated to reflect its provisions. These updated materials shall be made available to police officers in the regular course of their training and service.

(2) Medical cannabis-related activities shall be the lowest possible priority of the Police Department.

(3) Qualified patients, their primary caregivers, and MCDCs who come into contact with law enforcement shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if they are in compliance with the provisions of this Chapter.

(4) Qualified patients, their primary caregivers, and MCDCs who come into contact with law enforcement and cannot establish or demonstrate their status as a qualified patient, primary caregiver, or MCDC, but are otherwise in compliance with the provisions of this Chapter, shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if (1) based on the activity and circumstances, the officer determines that there is no evidence of criminal activity; (2) the claim by a qualified patient, primary caregiver, or MCDC is credible; and (3) proof of status as a qualified patient, primary caregiver, or MCDC can be provided to the Police Department within three (3) business days of the date of contact with law enforcement.

Operational Standards

(1) Signs displayed on the exterior of the property shall conform to existing regulations;

(2) The location shall be monitored at all times by a closed circuit video recording system for security purposes. The camera and recording system must be of adequate quality, color rendition, and resolution to allow the ready identification of any individual committing a crime anywhere on the site;

(3) The location shall have a centrally-monitored alarm system;

(4) Interior building lighting, exterior building lighting and parking area lighting must be in compliance with applicable regulations, and must be of sufficient brightness and color rendition so as to allow the ready identification of any individual committing a crime on site at a distance of no less than 40 feet (a distance that should allow a person reasonable reaction time upon recognition of a viable threat);

(5) Adequate overnight security shall be maintained so as to prevent unauthorized entry;

(6) Absolutely no cannabis product may be visible from the building exterior;

(7) Any beverage or edible produced, provided, or sold at the MCDC containing cannabis shall be so identified, as part of the packaging, with a prominent and clearly legible warning advising that the product contains cannabis and that is it to be consumed only by qualified patients;

(8) No persons under the age of 18 shall be allowed on site, unless the individual is a qualified patient and accompanied by his or her parent or documented legal guardian;

(9) At any given time, no MCDC may possess more cannabis or cannabis plants than would reasonably meet the needs of its registered patient members;

(10) A sign shall be posted in a conspicuous location inside the structure advising: "The diversion of cannabis (marijuana) for non-medical purposes is a violation of state law and will result in membership expulsion. Loitering at the location of a Medical Cannabis Dispensing Collective is also grounds for expulsion. The use of cannabis may impair a person's ability to drive a motor vehicle or operate heavy machinery.;

(11) No MCDC may provide medical cannabis to any persons other than qualified patients and designated primary caregivers who are registered members of the MCDC and whose status to possess cannabis pursuant to state law has been verified. No medical cannabis provided to a primary caregiver may be supplied to any person(s) other than the qualified patient(s) who designated the primary caregiver;

(12) No outdoor cultivation shall occur at an MCDC location unless it is: a) not visible from anywhere outside of the MCDC property and b) secured from public access by means of a locked gate and any other security measures necessary to prevent unauthorized entry;

(13) No MCDC shall cause or permit the establishment or maintenance of the sale or dispensing of alcoholic beverages for consumption on the premises or off-site of the premises;

(14) No dried medical cannabis shall be stored in structures without at least four walls and a roof, or stored in an unlocked vault or safe, or other unsecured storage structure; nor shall any dried medical cannabis be stored in a safe or vault that is not bolted to the floor or structure of the facility; and

(15) Medical cannabis may be consumed on-site only as follows:

a. The smoking or vaporizing of medical cannabis shall be allowed provided that appropriate seating, restrooms, drinking water, ventilation, air purification system, and patient supervision are provided in a room or enclosed area separate from other MCDC service areas.

b. The maximum occupancy of the on-site consumption area shall meet applicable occupancy requirements.

c. The MCDC shall use an activated charcoal filter, or other device sufficient to eliminate all odors associated with medical cannabis use from adjoining businesses and public walkways. The fan used to move air through the filter shall have the capacity sufficient to ventilate the square footage of the separate room or enclosed area in which medical cannabis use is permitted.

(16) MCDCs must verify that each member (1) is legally entitled to posses or consume medical cannabis pursuant to state law; and (2) is a resident of the State of California.

(17) All MCDC operators, employees, managers, members, or agents shall be qualified patients or the designated primary caregivers of qualified patients. MCDC operators, employees, managers, members, or agents shall not sell, barter, give away, or furnish medicine to anyone who is not a qualified patient or primary caregiver, registered as a member of the MCDC, and entitled to possess cannabis under state law.

(18) MCDCs shall maintain accurate patient records necessary to demonstrate patient eligibility under the law for every MCDC member, including (1) a copy of a valid driver's license or Department of Motor Vehicle identification card, (2) a patient registration form, and (3) a current valid letter of recommendation for the use of medical cannabis written by a state-licensed physician. All patient records shall be kept in a secure location, regarded as strictly confidential, and shall not be provided to law enforcement without a valid subpoena or court order.

(19) Operating hours for MCDCs shall not exceed the hours between 8:00 AM and 10:00 PM daily.

(20) MCDCs must have at least one security guard with a Guard Card issued by the California Department of Consumer Affairs on duty during operating hours.

Severability

If any section, sub-section, paragraph, sentence, or word of this Article is deemed to be invalid, the invalidity of such provision shall not affect the validity of any other sections, sub-sections, paragraphs, sentences, or words of this Article, or the application thereof; and to that end, the sections, sub-sections, paragraphs, sentences, and words of this Article shall be deemed severable.

Antoinette Mann - tocc mtg 01/12/16 pub hear marijuana cultivation

From: Iqbal Quidwai <i.quidwai@gmail.com>
To: Antoinette Mann <amann@toaks.org>, CityClerk <CCO@toaks.org>
Date: 1/8/2016 9:52 PM
Subject: tocc mtg 01/12/16 pub hear marijuana cultivation

Debbie Wasserman SchultzCreditStephen Voss for The New York Times Ja n 10th 2016

You're one of a dwindling number of progressive politicians who oppose legalization of even the medical use of marijuana. Where does that come from? I don't oppose the use of medical marijuana. I just don't think we should legalize more mind-altering substances if we want to make it less likely that people travel down the path toward using drugs. We have had a resurgence of drug use instead of a decline. There is a huge heroin epidemic.

Heroin addiction often starts with prescribed painkillers. Pill mills were a problem in Florida, but the state didn't make prescribing opiates illegal. There is a difference between opiates and marijuana.**comment**

++

the above is a courageous & poignant comment on this sensitive issue:
I think the Plann Comm made a mistake; we cannot have a blanket ban in 2016 after the legislatures action as well as our experience on the war on drugs!
@ a MINIMUM WE NEED TO ALLOW GROWING BY PATIENTS (SIMI) AND CAREGIVERS (VENTURA).

NICK *Iqbal Quidwai* Director

CONCERNED CITZ T. OAKS

Newbury Park CA 91320-1821 USA I.quidwai at gmail.com

https://www.youtube.com/user/iquidwai/videos

https://www.blogger.com/blogger.g?blogID=132131124170003710 9#allposts

https://www.facebook.com/iquidwai

http://www.cctoaks.com/

TO COUNCIL 1-12-2016
AGENDA ITEM NO. 8.A.
MEETING DATE 1-12-2016

From: Joe Kyle <joejek3@aol.com>
To: "tnoonan@toaks.org" <tnoonan@toaks.org>
Date: 1/11/2016 10:09 AM
Subject: Medical Marijuana Ordinance

Hello Tracy,

My name is Joe Kyle. I dropped off some papers today, at the front desk of the city council/city attorney. It is regarding permission, from the secretary of agriculture, that a city needs to ban production of a crop. As states in the MMRSA. Cannabis is now classified as an agricultural product. I am available to speak with you on this matter, over the phone, or in person. I can be reached at (805)807-5303. I am available to meet later this afternoon. Please let me know if you have any questions, comments, or concerns.

Joe Kyle

APPROVAL FOR NEW ORDINANCES REGULATING PLANTS, SEEDS OR CROPS REQUIRED BY CALIFORNIA SECRETARY OF AGRICULTURE

On October 9th, 2015 SEC. 6. of AB243 added Section 11362.777 to the Health and Safety Code, which states: *(a) The Department of Food and Agriculture shall establish a Medical Cannabis Cultivation Program to be administered by the secretary, except as specified in subdivision (c), shall administer this section as it pertains to the cultivation of medical marijuana. For purposes of this section and Chapter 3.5 (commencing with Section 19300) of the Business and Professions Code, medical cannabis is an agricultural product.*

As the MMRSA (AB266, AB243 and SB643) now require the tracking and regulation of cannabis from seed to sale in the state of California, and AB 243 of the MMRSA declares cannabis to be an agricultural crop in the state of California, all new local regulations are subject to SEC. 52334 of the Food and Agricultural Code which states: *Notwithstanding any other law, on and after January 1, 2015, a city, county, or district, including a charter city or county, shall not adopt or enforce an ordinance that regulates plants, crops, or seeds without the consent of the secretary. An ordinance enacted before January 1, 2015, shall be considered part of the comprehensive program of the department and shall be enforceable.*

Assembly Bill No. 243

CHAPTER 688

An act to add Article 6 (commencing with Section 19331), Article 13 (commencing with Section 19350), and Article 17 (commencing with Section 19360) to Chapter 3.5 of Division 8 of the Business and Professions Code, to add Section 12029 to the Fish and Game Code, to add Sections 11362.769 and 11362.777 to the Health and Safety Code, and to add Section 13276 to the Water Code, relating to medical marijuana, and making an appropriation therefor.

[Approved by Governor October 09, 2015. Filed with Secretary of State October 09, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 243, Wood. Medical marijuana.

Existing law, the Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 5, 1996, statewide general election, authorizes the use of marijuana for medical purposes. Existing law enacted by the Legislature requires the establishment of a program for the issuance of identification cards to qualified patients so that they may lawfully use marijuana for medical purposes, and requires the establishment of guidelines for the lawful cultivation of marijuana grown for medical use. Existing law provides for the licensure of various professions by boards or bureaus within the Department of Consumer Affairs. Existing law, the Sherman Food, Drug, and Cosmetic Law, provides for the regulation of food, drugs, devices, and cosmetics, as specified. A violation of that law is a crime.

This bill would require the Department of Food and Agriculture, the Department of Pesticide Regulation, the State Department of Public Health, the Department of Fish and Wildlife, and the State Water Resources Control Board to promulgate regulations or standards relating to medical marijuana and its cultivation, as specified. The bill would also require various state agencies to take specified actions to mitigate the impact that marijuana cultivation has on the environment. By requiring cities, counties, and their local law enforcement agencies to coordinate with state agencies to enforce laws addressing the environmental impacts of medical marijuana cultivation, and by including medical marijuana within the Sherman Act, the bill would impose a state-mandated local program.

This bill would require a state licensing authority to charge each licensee under the act a licensure and renewal fee, as applicable, and would further require the deposit of those collected fees into an account specific to that licensing authority in the Medical Marijuana Regulation and Safety Act Fund, which this bill would establish. This bill would impose certain fines and civil penalties for specified violations of the Medical Marijuana Regulation and Safety Act, and would require moneys collected as a result of these fines and civil penalties to be deposited into the Medical Cannabis Fines and Penalties Account, which this bill would establish within the fund. Moneys in the fund and each account of the fund would be available upon appropriation of the Legislature.

This bill would authorize the Director of Finance to provide an initial operating loan from the General Fund to the Medical Marijuana Regulation and Safety Act Fund of up to $10,000,000, and would appropriate $10,000,000 from the Medical Marijuana Regulation and Safety Act Fund to the Department of Consumer Affairs to begin the

activities of the bureau.

This bill would provide that its provisions are severable.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

This bill would become operative only if AB 266 and SB 643 of the 2015–16 Regular Session are enacted and take effect on or before January 1, 2016.

Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Article 6 (commencing with Section 19331) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 6. Licensed Cultivation Sites

19331. The Legislature finds and declares all of the following:

(a) The United States Environmental Protection Agency has not established appropriate pesticide tolerances for, or permitted the registration and lawful use of, pesticides on cannabis crops intended for human consumption pursuant to the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.).

(b) The use of pesticides is not adequately regulated due to the omissions in federal law, and cannabis cultivated in California for California patients can and often does contain pesticide residues.

(c) Lawful California medical cannabis growers and caregivers urge the Department of Pesticide Regulation to provide guidance, in absence of federal guidance, on whether the pesticides currently used at most cannabis cultivation sites are actually safe for use on cannabis intended for human consumption.

19332. (a) The Department of Food and Agriculture shall promulgate regulations governing the licensing of indoor and outdoor cultivation sites.

(b) The Department of Pesticide Regulation, in consultation with the Department of Food and Agriculture, shall develop standards for the use of pesticides in cultivation, and maximum tolerances for pesticides and other foreign object residue in harvested cannabis.

(c) The State Department of Public Health shall develop standards for the production and labeling of all edible medical cannabis products.

(d) The Department of Food and Agriculture, in consultation with the Department of Fish and Wildlife and the State Water Resources Control Board, shall ensure that individual and cumulative effects of water diversion and discharge associated with cultivation do not affect the instream flows needed for fish spawning, migration, and rearing, and the flows needed to maintain natural flow variability.

(e) The Department of Food and Agriculture shall have the authority necessary for the implementation of the regulations it adopts pursuant to this chapter. The regulations shall do all of the following:

(1) Provide that weighing or measuring devices used in connection with the sale or distribution of medical cannabis are required to meet standards equivalent to Division 5 (commencing with Section 12001).

(2) Require that cannabis cultivation by licensees is conducted in accordance with state and local laws related to land conversion, grading, electricity usage, water usage, agricultural discharges, and similar matters. Nothing in this chapter, and no regulation adopted by the department, shall be construed to supersede or limit the authority of the State Water Resources Control Board, regional water quality control boards, or the Department of Fish and Wildlife to implement and enforce their statutory obligations or to adopt regulations to protect water

quality, water supply, and natural resources.

(3) Establish procedures for the issuance and revocation of unique identifiers for activities associated with a cannabis cultivation license, pursuant to Article 8 (commencing with Section 19337). All cannabis shall be labeled with the unique identifier issued by the Department of Food and Agriculture.

(4) Prescribe standards, in consultation with the bureau, for the reporting of information as necessary related to unique identifiers, pursuant to Article 8 (commencing with Section 19337).

(f) The Department of Pesticide Regulation, in consultation with the State Water Resources Control Board, shall promulgate regulations that require that the application of pesticides or other pest control in connection with the indoor or outdoor cultivation of medical cannabis meets standards equivalent to Division 6 (commencing with Section 11401) of the Food and Agricultural Code and its implementing regulations.

(g) State cultivator license types issued by the Department of Food and Agriculture include:

(1) Type 1, or "specialty outdoor," for outdoor cultivation using no artificial lighting of less than or equal to 5,000 square feet of total canopy size on one premises, or up to 50 mature plants on noncontiguous plots.

(2) Type 1A, or "specialty indoor," for indoor cultivation using exclusively artificial lighting of less than or equal to 5,000 square feet of total canopy size on one premises.

(3) Type 1B, or "specialty mixed-light," for cultivation using a combination of natural and supplemental artificial lighting at a maximum threshold to be determined by the licensing authority, of less than or equal to 5,000 square feet of total canopy size on one premises.

(4) Type 2, or "small outdoor," for outdoor cultivation using no artificial lighting between 5,001 and 10,000 square feet, inclusive, of total canopy size on one premises.

(5) Type 2A, or "small indoor," for indoor cultivation using exclusively artificial lighting between 5,001 and 10,000 square feet, inclusive, of total canopy size on one premises.

(6) Type 2B, or "small mixed-light," for cultivation using a combination of natural and supplemental artificial lighting at a maximum threshold to be determined by the licensing authority, between 5,001 and 10,000 square feet, inclusive, of total canopy size on one premises.

(7) Type 3, or "outdoor," for outdoor cultivation using no artificial lighting from 10,001 square feet to one acre, inclusive, of total canopy size on one premises. The Department of Food and Agriculture shall limit the number of licenses allowed of this type.

(8) Type 3A, or "indoor," for indoor cultivation using exclusively artificial lighting between 10,001 and 22,000 square feet, inclusive, of total canopy size on one premises. The Department of Food and Agriculture shall limit the number of licenses allowed of this type.

(9) Type 3B, or "mixed-light," for cultivation using a combination of natural and supplemental artificial lighting at a maximum threshold to be determined by the licensing authority, between 10,001 and 22,000 square feet, inclusive, of total canopy size on one premises. The Department of Food and Agriculture shall limit the number of licenses allowed of this type.

(10) Type 4, or "nursery," for cultivation of medical cannabis solely as a nursery. Type 4 licensees may transport live plants.

19333. An employee engaged in commercial cannabis cultivation activity shall be subject to Wage Order 4-2001 of the Industrial Welfare Commission.

SEC. 2. Article 13 (commencing with Section 19350) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 13. Funding

19350. Each licensing authority shall establish a scale of application, licensing, and renewal fees, based upon the cost of enforcing this chapter, as follows:

(a) Each licensing authority shall charge each licensee a licensure and renewal fee, as applicable. The licensure and renewal fee shall be calculated to cover the costs of administering this chapter. The licensure fee may vary

depending upon the varying costs associated with administering the various regulatory requirements of this chapter as they relate to the nature and scope of the different licensure activities, including, but not limited to, the track and trace program required pursuant to Section 19335, but shall not exceed the reasonable regulatory costs to the licensing authority.

(b) The total fees assessed pursuant to this chapter shall be set at an amount that will fairly and proportionately generate sufficient total revenue to fully cover the total costs of administering this chapter.

(c) All license fees shall be set on a scaled basis by the licensing authority, dependent on the size of the business.

(d) The licensing authority shall deposit all fees collected in a fee account specific to that licensing authority, to be established in the Medical Marijuana Regulation and Safety Act Fund. Moneys in the licensing authority fee accounts shall be used, upon appropriation of the Legislature, by the designated licensing authority for the administration of this chapter.

19351. (a) The Medical Marijuana Regulation and Safety Act Fund is hereby established within the State Treasury. Moneys in the fund shall be available upon appropriation by the Legislature. Notwithstanding Section 16305.7 of the Government Code, the fund shall include any interest and dividends earned on the moneys in the fund.

(b) (1) Funds for the establishment and support of the regulatory activities pursuant to this chapter shall be advanced as a General Fund or special fund loan, and shall be repaid by the initial proceeds from fees collected pursuant to this chapter or any rule or regulation adopted pursuant to this chapter, by January 1, 2022. Should the initial proceeds from fees not be sufficient to repay the loan, moneys from the Medical Cannabis Fines and Penalties Account shall be made available to the bureau, by appropriation of the Legislature, to repay the loan.

(2) Funds advanced pursuant to this subdivision shall be appropriated to the bureau, which shall distribute the moneys to the appropriate licensing authorities, as necessary to implement the provisions of this chapter.

(3) The Director of Finance may provide an initial operating loan from the General Fund to the Medical Marijuana Regulation and Safety Act Fund that does not exceed ten million dollars ($10,000,000).

(c) Except as otherwise provided, all moneys collected pursuant to this chapter as a result of fines or penalties imposed under this chapter shall be deposited directly into the Medical Marijuana Fines and Penalties Account, which is hereby established within the fund, and shall be available, upon appropriation by the Legislature to the bureau, for the purposes of funding the enforcement grant program pursuant to subdivision (d).

(d) (1) The bureau shall establish a grant program to allocate moneys from the Medical Cannabis Fines and Penalties Account to state and local entities for the following purposes:

(A) To assist with medical cannabis regulation and the enforcement of this chapter and other state and local laws applicable to cannabis activities.

(B) For allocation to state and local agencies and law enforcement to remedy the environmental impacts of cannabis cultivation.

(2) The costs of the grant program under this subdivision shall, upon appropriation by the Legislature, be paid for with moneys in the Medical Cannabis Fines and Penalties Account.

(3) The grant program established by this subdivision shall only be implemented after the loan specified in this section is repaid.

19352. The sum of ten million dollars ($10,000,000) is hereby appropriated from the Medical Marijuana Regulation and Safety Act Fund to the Department of Consumer Affairs to begin the activities of the Bureau of Medical Marijuana Regulation. Funds appropriated pursuant to this section shall not include moneys received from fines or penalties.

SEC. 3. Article 17 (commencing with Section 19360) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 17. Penalties and Violations

19360. (a) A person engaging in cannabis activity without a license and associated unique identifiers required by

this chapter shall be subject to civil penalties of up to twice the amount of the license fee for each violation, and the department, state or local authority, or court may order the destruction of medical cannabis associated with that violation. Each day of operation shall constitute a separate violation of this section. All civil penalties imposed and collected pursuant to this section shall be deposited into the Marijuana Production and Environment Mitigation Fund established pursuant to Section 31013 of the Revenue and Taxation Code.

(b) If an action for civil penalties is brought against a licensee pursuant to this chapter by the Attorney General, the penalty collected shall be deposited into the General Fund. If the action is brought by a district attorney or county counsel, the penalty collected shall be paid to the treasurer of the county in which the judgment was entered. If the action is brought by a city attorney or city prosecutor, the penalty collected shall be paid to the treasurer of the city or city and county in which the judgment was entered. If the action is brought by a city attorney and is adjudicated in a superior court located in the unincorporated area or another city in the same county, the penalty shall be paid one-half to the treasurer of the city in which the complaining attorney has jurisdiction and one-half to the treasurer of the county in which the judgment is entered.

(c) Notwithstanding subdivision (a), criminal penalties shall continue to apply to an unlicensed person or entity engaging in cannabis activity in violation of this chapter, including, but not limited to, those individuals covered under Section 11362.7 of the Health and Safety Code.

SEC. 4. Section 12029 is added to the Fish and Game Code, to read:

12029. (a) The Legislature finds and declares all of the following:

(1) The environmental impacts associated with marijuana cultivation have increased, and unlawful water diversions for marijuana irrigation have a detrimental effect on fish and wildlife and their habitat, which are held in trust by the state for the benefit of the people of the state.

(2) The remediation of existing marijuana cultivation sites is often complex and the permitting of these sites requires greater department staff time and personnel expenditures. The potential for marijuana cultivation sites to significantly impact the state's fish and wildlife resources requires immediate action on the part of the department's lake and streambed alteration permitting staff.

(b) In order to address unlawful water diversions and other violations of the Fish and Game Code associated with marijuana cultivation, the department shall establish the watershed enforcement program to facilitate the investigation, enforcement, and prosecution of these offenses.

(c) The department, in coordination with the State Water Resources Control Board, shall establish a permanent multiagency task force to address the environmental impacts of marijuana cultivation. The multiagency task force, to the extent feasible and subject to available Resources, shall expand its enforcement efforts on a statewide level to ensure the reduction of adverse impacts of marijuana cultivation on fish and wildlife and their habitats throughout the state.

(d) In order to facilitate the remediation and permitting of marijuana cultivation sites, the department shall adopt regulations to enhance the fees on any entity subject to Section 1602 for marijuana cultivation sites that require remediation. The fee schedule established pursuant to this subdivision shall not exceed the fee limits in Section 1609.

SEC. 5. Section 11362.769 is added to the Health and Safety Code, to read:

11362.769. Indoor and outdoor medical marijuana cultivation shall be conducted in accordance with state and local laws related to land conversion, grading, electricity usage, water usage, water quality, woodland and riparian habitat protection, agricultural discharges, and similar matters. State agencies, including, but not limited to, the State Board of Forestry and Fire Protection, the Department of Fish and Wildlife, the State Water Resources Control Board, the California regional water quality control boards, and traditional state law enforcement agencies shall address environmental impacts of medical marijuana cultivation and shall coordinate, when appropriate, with cities and counties and their law enforcement agencies in enforcement efforts.

SEC. 6. Section 11362.777 is added to the Health and Safety Code, to read:

11362.777. (a) The Department of Food and Agriculture shall establish a Medical Cannabis Cultivation Program to be administered by the secretary, except as specified in subdivision (c), shall administer this section as it

pertains to the cultivation of medical marijuana. For purposes of this section and Chapter 3.5 (commencing with Section 19300) of the Business and Professions Code, medical cannabis is an agricultural product.

(b) (1) A person or entity shall not cultivate medical marijuana without first obtaining both of the following:

(A) A license, permit, or other entitlement, specifically permitting cultivation pursuant to these provisions, from the city, county, or city and county in which the cultivation will occur.

(B) A state license issued by the department pursuant to this section.

(2) A person or entity shall not submit an application for a state license issued by the department pursuant to this section unless that person or entity has received a license, permit, or other entitlement, specifically permitting cultivation pursuant to these provisions, from the city, county, or city and county in which the cultivation will occur.

(3) A person or entity shall not submit an application for a state license issued by the department pursuant to this section if the proposed cultivation of marijuana will violate the provisions of any local ordinance or regulation, or if medical marijuana is prohibited by the city, county, or city and county in which the cultivation is proposed to occur, either expressly or otherwise under principles of permissive zoning.

(c) (1) Except as otherwise specified in this subdivision, and without limiting any other local regulation, a city, county, or city and county, through its current or future land use regulations or ordinance, may issue or deny a permit to cultivate medical marijuana pursuant to this section. A city, county, or city and county may inspect the intended cultivation site for suitability prior to issuing a permit. After the city, county, or city and county has approved a permit, the applicant shall apply for a state medical marijuana cultivation license from the department. A locally issued cultivation permit shall only become active upon licensing by the department and receiving final local approval. A person shall not cultivate medical marijuana prior to obtaining both a permit from the city, county, or city and county and a state medical marijuana cultivation license from the department.

(2) A city, county, or city and county that issues or denies conditional licenses to cultivate medical marijuana pursuant to this section shall notify the department in a manner prescribed by the secretary.

(3) A city, county, or city and county's locally issued conditional permit requirements must be at least as stringent as the department's state licensing requirements.

(4) If a city, county, or city and county does not have land use regulations or ordinances regulating or prohibiting the cultivation of marijuana, either expressly or otherwise under principles of permissive zoning, or chooses not to administer a conditional permit program pursuant to this section, then commencing March 1, 2016, the division shall be the sole licensing authority for medical marijuana cultivation applicants in that city, county, or city and county.

(d) (1) The secretary may prescribe, adopt, and enforce regulations relating to the implementation, administration, and enforcement of this part, including, but not limited to, applicant requirements, collections, reporting, refunds, and appeals.

(2) The secretary may prescribe, adopt, and enforce any emergency regulations as necessary to implement this part. Any emergency regulation prescribed, adopted, or enforced pursuant to this section shall be adopted in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and, for purposes of that chapter, including Section 11349.6 of the Government Code, the adoption of the regulation is an emergency and shall be considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, and general welfare.

(3) The secretary may enter into a cooperative agreement with a county agricultural commissioner to carry out the provisions of this chapter, including, but not limited to, administration, investigations, inspections, licensing and assistance pertaining to the cultivation of medical marijuana. Compensation under the cooperative agreement shall be paid from assessments and fees collected and deposited pursuant to this chapter and shall provide reimbursement to the county agricultural commissioner for associated costs.

(e) (1) The department, in consultation with, but not limited to, the Bureau of Medical Marijuana Regulation, the State Water Resources Control Board, and the Department of Fish and Wildlife, shall implement a unique identification program for medical marijuana. In implementing the program, the department shall consider issues, including, but not limited to, water use and environmental impacts. In implementing the program, the department shall ensure that:

(A) Individual and cumulative effects of water diversion and discharge associated with cultivation do not affect the instream flows needed for fish spawning, migration, and rearing, and the flows needed to maintain natural flow variability.

(B) Cultivation will not negatively impact springs, riparian wetlands, and aquatic habitats.

(2) The department shall establish a program for the identification of permitted medical marijuana plants at a cultivation site during the cultivation period. The unique identifier shall be attached at the base of each plant. A unique identifier, such as, but not limited to, a zip tie, shall be issued for each medical marijuana plant.

(A) Unique identifiers will only be issued to those persons appropriately licensed by this section.

(B) Information associated with the assigned unique identifier and licensee shall be included in the trace and track program specified in Section 19335 of the Business and Professions Code.

(C) The department may charge a fee to cover the reasonable costs of issuing the unique identifier and monitoring, tracking, and inspecting each medical marijuana plant.

(D) The department may promulgate regulations to implement this section.

(3) The department shall take adequate steps to establish protections against fraudulent unique identifiers and limit illegal diversion of unique identifiers to unlicensed persons.

(f) (1) A city, county, or city and county that issues or denies licenses to cultivate medical marijuana pursuant to this section shall notify the department in a manner prescribed by the secretary.

(2) Unique identifiers and associated identifying information administered by a city or county shall adhere to the requirements set by the department and be the equivalent to those administered by the department.

(g) This section does not apply to a qualified patient cultivating marijuana pursuant to Section 11362.5 if the area he or she uses to cultivate marijuana does not exceed 100 square feet and he or she cultivates marijuana for his or her personal medical use and does not sell, distribute, donate, or provide marijuana to any other person or entity. This section does not apply to a primary caregiver cultivating marijuana pursuant to Section 11362.5 if the area he or she uses to cultivate marijuana does not exceed 500 square feet and he or she cultivates marijuana exclusively for the personal medical use of no more than five specified qualified patients for whom he or she is the primary caregiver within the meaning of Section 11362.7 and does not receive remuneration for these activities, except for compensation provided in full compliance with subdivision (c) of Section 11362.765. For purposes of this section, the area used to cultivate marijuana shall be measured by the aggregate area of vegetative growth of live marijuana plants on the premises. Exemption from the requirements of this section does not limit or prevent a city, county, or city and county from regulating or banning the cultivation, storage, manufacture, transport, provision, or other activity by the exempt person, or impair the enforcement of that regulation or ban.

SEC. 7. Section 13276 is added to the Water Code, to read:

13276. (a) The multiagency task force, the Department of Fish and Wildlife and State Water Resources Control Board pilot project to address the Environmental Impacts of Cannabis Cultivation, assigned to respond to the damages caused by marijuana cultivation on public and private lands in California, shall continue its enforcement efforts on a permanent basis and expand them to a statewide level to ensure the reduction of adverse impacts of marijuana cultivation on water quality and on fish and wildlife throughout the state.

(b) Each regional board shall, and the State Water Resources Control Board may, address discharges of waste resulting from medical marijuana cultivation and associated activities, including by adopting a general permit, establishing waste discharge requirements, or taking action pursuant to Section 13269. In addressing these discharges, each regional board shall include conditions to address items that include, but are not limited to, all of the following:

(1) Site development and maintenance, erosion control, and drainage features.

(2) Stream crossing installation and maintenance.

(3) Riparian and wetland protection and management.

(4) Soil disposal.

(5) Water storage and use.

(6) Irrigation runoff.

(7) Fertilizers and soil.

(8) Pesticides and herbicides.

(9) Petroleum products and other chemicals.

(10) Cultivation-related waste.

(11) Refuse and human waste.

(12) Cleanup, restoration, and mitigation.

SEC. 8. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 10. This measure shall become operative only if both Assembly Bill 266 and Senate Bill 643 of the 2015–16 Regular Session are enacted and become operative.

Assembly Bill No. 2470

CHAPTER 294

An act to amend Sections 52256.5, 52288, 52332, and 52452 of, and to add Section 52334 to, the Food and Agricultural Code, relating to seed.

[Approved by Governor August 25, 2014. Filed with Secretary of State August 25, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2470, Salas. California Seed Law.

Existing law, the California Seed Law, regulates seed sold in California, and requires each container of agricultural seed that is for sale or sold within this state for sowing purposes to be labeled, as specified, unless the sale is an occasional sale of seed grain by the producer of the seed grain to his neighbor for use by the purchaser within the county of production. Existing law defines "person" for purposes of the California Seed Law to mean an individual, partnership, trust association, cooperative association, or any other business unit or organization.

This bill would clarify that definition of "person" to include corporations. The bill would also clarify the term "neighbor" for purposes of the labeling requirements specified above to mean a person who lives in close proximity, not to exceed 3 miles, to another. The bill would revise a statement of legislative intent to include ensuring that the amount of seed represented on a tag or label is properly identified.

Existing law authorizes the Secretary of Food and Agriculture, by regulation, to adopt a list of plants and crops that the secretary finds are or may be grown in this state from agricultural or vegetable seed.

This bill would instead authorize the secretary, by regulation, to adopt a list of plants and crops that the secretary finds are or may be grown in this state. The bill would also prohibit a city, county, or district, including a charter city or county, from adopting or enforcing an ordinance on or after January 1, 2015, that regulates plants, crops, or seeds without the consent of the secretary. The bill would make other nonsubstantive changes.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 52256.5 of the Food and Agricultural Code is amended to read:

52256.5. "Person" also means any individual, partnership, corporation, trust association, cooperative association, or any other business unit or organization.

SEC. 2. Section 52288 of the Food and Agricultural Code is amended to read:

52288. The Legislature hereby declares that it is the intent of this chapter to enable the seed industry, with the aid of the state, to ensure that seed purchased by the consumer-buyer is properly identified and of the quality

and amount represented on the tag or label. The Legislature further declares that the success of agriculture and the seed industry in this state depends upon the continued commitment to industry-funded research in order to improve the quality and variety of seed available to the consumer-buyer.

SEC. 3. Section 52332 of the Food and Agricultural Code is amended to read:

52332. The secretary, by regulation, may adopt all of the following:

(a) A list of the plants and crops that the secretary finds are or may be grown in this state.

(b) A list of the plants and crops that the secretary finds are detrimental to agriculture if they occur incidentally in other crops, and which, therefore, are classed as weed seed except if sold alone or as a specific constituent of a definite seed mixture.

(c) A list of noxious weed seed that the secretary finds are prohibited noxious weed seed, as defined in this chapter.

(d) A list of those noxious weed seed that are not classified as prohibited noxious weed seed and are classified by this chapter as restricted noxious weed seed.

(e) A list of substances that are likely to be used for treating grain or other crop seed that the secretary finds and determines are toxic to human beings or animals if used, and an appropriate warning or caution statement for each substance.

(f) (1) Establish methods and procedures, upon the recommendation of the board, for the conciliation, mediation, or arbitration of disputes between labelers and any persons concerning conformance with label statements, advertisements, or other disputes regarding the quality or performance of seed. The methods and procedures shall be a mandatory prerequisite to pursuing other dispute resolution mechanisms, including, but not limited to, litigation. However, if conciliation, mediation, or arbitration proceedings are commenced under this section to resolve a controversy, the statute of limitations that applies to a civil action concerning that controversy is tolled upon commencement of conciliation, mediation, or arbitration proceedings, and until 30 days after the completion of those proceedings. As used in this subdivision, "completion of those proceedings" means the filing of a statement of agreement or nonagreement by the conciliator or mediator, or the rendering of a decision by an arbitrator or arbitration committee.

(2) Conciliation, mediation, or arbitration shall not affect any enforcement action by the secretary pursuant to this chapter. Regulations adopted by the secretary for the mandatory conciliation, mediation, or arbitration of disputes shall require that adequate notice be provided on the seed label notifying any buyer of the requirement to submit a dispute to mandatory conciliation, mediation, or arbitration as a prerequisite to other dispute resolution mechanisms, including litigation.

(g) Establish additional labeling requirements for coated, pelleted, encapsulated, mat, tape, or any other germination medium or device used on seed in order that the purchaser or consumer will be informed as to the actual amount of seed purchased.

SEC. 4. Section 52334 is added to the Food and Agricultural Code, to read:

52334. Notwithstanding any other law, on and after January 1, 2015, a city, county, or district, including a charter city or county, shall not adopt or enforce an ordinance that regulates plants, crops, or seeds without the consent of the secretary. An ordinance enacted before January 1, 2015, shall be considered part of the comprehensive program of the department and shall be enforceable.

SEC. 5. Section 52452 of the Food and Agricultural Code is amended to read:

52452. (a) Except as otherwise provided in Section 52454, each container of agricultural seed that is for sale or sold within this state for sowing purposes, unless the sale is an occasional sale of seed grain by the producer of the seed grain to his or her neighbor for use by the purchaser within the county of production, shall bear upon it or have attached to it in a conspicuous place a plainly written or printed label or tag in the English language that includes all of the following information:

(1) The commonly accepted name of the kind, kind and variety, or kind and type of each agricultural seed component in excess of 5 percent of the whole, and the percentage by weight of each. If the aggregate of

agricultural seed components, each present in an amount not exceeding 5 percent of the whole, exceeds 10 percent of the whole, each component in excess of 1 percent of the whole shall be named together with the percentage by weight of each. If more than one component is required to be named, the names of all components shall be shown in letters of the same type and size.

(2) The lot number or other lot identification.

(3) The percentage by weight of all weed seeds.

(4) The name and approximate number of each kind of restricted noxious weed seed per pound.

(5) The percentage by weight of any agricultural seed except that which is required to be named on the label.

(6) The percentage by weight of inert matter. If a percentage by weight is required to be shown by any provision of this section, that percentage shall be exclusive of any substance that is added to the seed as a coating and shown on the label as such.

(7) For each agricultural seed in excess of 5 percent of the whole, stated in accordance with paragraph (1), the percentage of germination exclusive of hard seed, the percentage of hard seed, if present, and the calendar month and year the test was completed to determine the percentages. Following the statement of those percentages, the additional statement "total germination and hard seed" may be stated.

(8) The name and address of the person who labeled the seed or of the person who sells the seed within this state.

(b) All determinations of noxious weed seeds are subject to tolerances and methods of determination prescribed in the regulations that are adopted pursuant to this chapter.

(c) For purposes of this section, "neighbor" means a person who lives in close proximity, not to exceed three miles, to another.

Law Office of Charnel James
A New Dawn in Legal Representation
Charnel James, Esq

January 10, 2016

Attn: Clerk of the Board (Council)
(County)(City)(Council)
(Address)
(City), CA (ZIP)

RE: Recent state regulations that effect the proposed regulations on Medical Marijuana Cultivation

Dear Honorable Board Members (City Council Members)

The last six months have been very busy for legislatures as they have crafted and passed a number of regulations that affect the management and control of Medical Marijuana. This has caused some confusion to the local jurisdictions, and as a custody and on behalf of my various clients I am providing this legal analysis to assist you in your actions for the coming weeks.

The first item is the March 1 deadline to have some type of regulation in place. As you may be aware, there is an open letter to the jurisdictions from Assemblyman Jim Woods pertaining to that deadline. A copy of that letter is attached to this letter as Exhibit 1. The action to correct that typing error of the date will be addressed on January 13, 2016. Even if there is no quick action (as we are all aware of the speed in which the Assembly acts), based on the way that courts have interpreted the medical marijuana cases, that deadline would not stand up in court. (See the legal analysis provided by NORML attached as Exhibit 2.)

Since the March 1 deadline is not a hard and fast date, this jurisdiction can and should slow down this process by creating as ad hoc committee of stake holders in the jurisdiction to form the best land use regulation that would address most of the populous concerns (which includes patients, proponents and businesses.) It will also allow the jurisdiction the time that it needs to gain the review of the Secretary of Agriculture which is a requirement for any and all crops within California.

On October 9, 2015 the governor signed SEC. 6. Section 11362.777 in the Health and Safety Code which classified medical marijuana (cannabis) as an agricultural crop. (See code language attached as Exhibit 3.) In particular the language specifically states:

117 C Street
Marysville, CA 95901
cjames@charneljameslaw.com

main 530-923-4678
fax 530-634-9957

> "The Department of Food and Agriculture shall establish a Medical Cannabis Cultivation Program to be administered by the secretary, except as specified in subdivision (c), shall administer this section as it pertains to the cultivation of medical marijuana. For purposes of this section and Chapter 3.5 (commencing with Section 19300) of the Business and Professions Code, medical cannabis is an agricultural product."

Furthermore, under 52334 under the Agricultural Code, no local jurisdiction can make any regulation that controls and seeds, plants or process. (See attached Exhibit 4.) The exact language is as follows:

> "Notwithstanding any other law, on and after January 1, 2015, a city, county, or district, including a charter city or county, shall not adopt or enforce an ordinance that regulates plants, crops, or seeds without the consent of the secretary. An ordinance enacted before January 1, 2015, shall be considered part of the comprehensive program of the department and shall be enforceable."

The ordinance that you are proposing would require a review by the Secretary of Agriculture to obtain the review and approval of their department, prior to any actions by this Board (COUNCIL). I would strongly suggest that a delay at this point would be prudent in order for this Board to not be in violation of state law.

I would be happy to bring my constituents' concerns to this stakeholders' meeting, and am willing to work with you to help draft land use regulations that fit within MMRSA. Thank you for your time and attention to this matter.

Sincerely

Charnel James
Attorney at Law

117 C Street
Marysville, CA 95901
[redacted]

main 530-923-4678
fax 530-634-9957
[redacted]

COMMITTEES
APPROPRIATIONS
BUSINESS AND PROFESSIONS
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SELECT COMMITTEES
CHAIR, DIGITAL DIVIDE IN RURAL CALIFORNIA
CAREER TECHNICAL EDUCATION AND BUILDING A 21ST CENTURY WORKFORCE
WINE

Assembly
California Legislature

JIM WOOD
ASSEMBLYMEMBER, SECOND DISTRICT

STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0002
(916) 319-2002
FAX (916) 319-2102

DISTRICT OFFICES
50 D STREET, SUITE 450
SANTA ROSA, CA 95404
(707) 576-2526
FAX (707) 576-2297

710 E STREET, SUITE 150
EUREKA, CA 95501
(707) 445-7014
FAX (707) 455-6807

200 S SCHOOL STREET, SUITE D
UKIAH, CA 95482
(707) 462-5770
FAX (707) 463-5773

The Marijuana Regulation and Safety Act's March 1st Deadline

An open letter to County and City Government Officials:

Like many of my colleagues, I began my public service career at the local level where decisions made in Sacramento often have a profound impact on the decisions we make in our communities. Over the past several weeks, I have learned that cities and counties are scrambling to put regulations regarding medical marijuana in place ahead of a March 1st deadline that was inadvertently included in AB243 of the Medical Marijuana Regulation and Safety Act (MMRSA). As a former local elected I understand this reaction. However, I am writing this letter to clarify some of the confusion that has resulted from the inclusion of the March 1st deadline in the MMRSA.

The MMRSA will bring a multi-billion dollar industry that has grown up largely in the shadows into the light. Ultimately, the goal is to provide Californians with the legal, consumer, and environmental protections we have come to expect from any other industry.

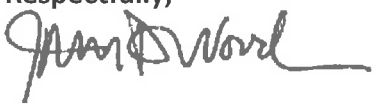
During the scramble at the end of the legislative session this year, an inadvertent drafting error placed a deadline on local jurisdictions, requiring them to adopt their own land use regulations for medical cannabis cultivation by March 1, 2016, or turn that responsibility over to the state. As soon as I was aware of the error I published a letter in the Assembly Journal, the official record of the Assembly, declaring my intention to pass urgency legislation as soon as the legislature reconvenes in January. The compromise agreement with the Governor's office did not include the March 1st deadline and this urgency legislation will ensure that the MMRSA's legislative intent is not altered. I have already amended one of my bills with language that will strike the deadline and maintain a local jurisdiction's ability to create their own regulations. As an urgency measure, the law will go into effect as soon as it is signed by the Governor.

My intent to remove the deadline has bi-partisan and stakeholder support. The Governor's office is prepared to partner with my office to ensure local control on this issue. I appreciate the Governor's acknowledgement of this drafting error and his office's willingness to work with me to quickly resolve the problem. Even if my urgency measure is not signed until after March 1st,

the Bureau of Medical Marijuana Regulation (BMMR), the entity responsible for developing the State's regulations, currently exists on paper only. It will be many months before the Bureau has the capacity to develop and enforce statewide regulations. Additionally we have received legal feedback confirming that once my urgency measure is in effect jurisdictions will retain the local control they need.

I am confident that my colleagues and I will eliminate the March 1st deadline before it becomes a realistic problem as opposed to a theoretical concern for local lawmakers.

Respectfully,



JIM WOOD
ASSEMBLYMEMBER, 2ND DISTRICT

January 8, 2015

An open letter to Boards of Supervisors, City Councils, County Counsels and City Attorneys in California

As you may be aware, Rep. Woods has issued an open letter to City and County officials in California regarding the "drafting error" that has lead many local jurisdictions to impose restrictive laws against medical marijuana before March 1 (see http://www.canorml.org/woodsletter.pdf). Now, Reps. Woods, Cooley, Jones-Sawyer, Lackey and Bonta have introduced an urgency measure, AB 21, which repeals the March 1 deadline for local action in MMRSA, the 2015 state law that regulates medical marijuana. The repeal is supported by the League of Cities, CSAC, and the RCRC. It is heading to its third reading in the Senate on track to be signed by the Governor within the month.

Even if the repeal does not pass, it is California NORML's opinion that local action is not required in order to retain local control over medical marijuana activities.

Question Presented: Does Health & Safety Code Section 11362.777 Cause Local Governments to Permanently Lose Their Authority to Regulate Medical Cannabis Cultivation if They Fail to Affirmatively Act by March 1, 2016?

I. Introduction

In enacting the Medical Marijuana Regulation & Safety Act (hereinafter, "MMRSA"), the California Legislature added Section 11362.777 to the Health & Safety Code (hereinafter, "Section 11362.777"). Subsection (c)(4) of Section 11362.777 provides in full that:

> If a city, county, or city and county does not have land use regulations or ordinances regulating or prohibiting the cultivation of marijuana, either expressly or otherwise under principles of permissive zoning, or chooses not to administer a conditional permit program pursuant to this section, then commencing March 1, 2016, the division shall be the sole licensing authority for medical marijuana cultivation applicants in that city, county, or city and county.

Thus, Section 11362.777 clearly requires the California Department of Food & Agriculture (hereinafter, "CDFA") to act as the "sole licensing authority" for applicants seeking to conduct medical cannabis cultivation under MMRSA if a local government fails to affirmatively regulate or prohibit medical cannabis cultivation by March 1, 2016. *See* Bus. & Profs. Code § 19300.5(w) ("'Licensing authority' means the state agency responsible for the issuance, renewal, or reinstatement of the license, or the state agency authorized to take disciplinary action against the license."). In other words, rather than requiring medical cannabis cultivators to possess both a state license and local permit, Section 11362.777 allows medical cannabis cultivators under MMRSA to only possess a state license if a local government fails to affirmatively regulate or prohibit medical cannabis cultivation by March 1, 2016. However, the plain language of Section 11362.777 is unclear whether local governments permanently lose their authority to regulate medical cannabis cultivation if they fail to act by March 1, 2016.

II. Analysis

There are those who believe Section 11362.777 causes local governments to permanently lose their authority to regulate medical cannabis cultivation if they fail to affirmatively regulate or prohibit medical cannabis cultivation by March 1, 2016. Essentially, they interpret Subsection (c)(4) of Section 11362.777 as stating:

> If a local government does not have land use regulations or ordinances affirmatively regulating or prohibiting medical cannabis cultivation, then commencing March 1, 2016, CDFA shall be—***forever and always***—the sole licensing authority for medical marijuana cultivation applicants in that city, county, or city and county.

However, Subsection (c)(4) of Section 11362.777 could just as easily be interpreted as stating:

> If a local government does not have land use regulations or ordinances affirmatively regulating or prohibiting medical cannabis cultivation, then commencing March 1, 2016, CDFA shall be—***for the time being***—the sole licensing authority for medical marijuana cultivation applicants in that city, county, or city and county.

Thus, the plain language of Section 11362.777 is ambiguous on whether local governments permanently lose their authority to regulate medical cannabis cultivation if they fail to affirmatively regulate or prohibit medical cannabis cultivation by March 1, 2016.

III. Conclusion

Being ambiguous as a matter of plain language, Section 11362.777 should be evaluated in light of how a California court would likely interpret the provision. It is well established that California courts consider a local government's authority to affirmatively regulate or prohibit medical cannabis cultivation as within its "traditional land use and police powers . . . ." *See City of Riverside v. Inland Empire Patients Health & Wellness Ctr., Inc.*, 56 Cal. 4th 729, 762 (2013); *Maral v. City of Live Oak*, 221 Cal. App. 4th 975, 978 (2013) ("Accordingly, we conclude the CUA and MMP do not preempt a city's police power to prohibit the cultivation of all marijuana within that city."). "Consistent with this principle, when local government regulates in an area over which it traditionally has exercised control, such as the location of particular land uses, California courts will presume, absent a ***clear indication*** of preemptive intent from the Legislature, that such regulation is not preempted by state statute." *City of Riverside v. Inland Empire Patients Health & Wellness Ctr., Inc.*, 56 Cal. 4th 729, 743 (2013) (emphasis added) (internal quotation marks omitted). "[A]mbiguous provisions fail to provide that ***clear indication***." *Kirby v. Cnty. of Fresno*, F070056, at *2–3 (Cal. Ct. App. 5th Dist. Dec. 12, 2015) (emphasis added). Because of the ambiguous plain language, a California court will likely decide that Section 11362.777 ***does not*** cause local governments to permanently lose their authority to regulate medical cannabis cultivation if they fail to affirmatively regulate or prohibit medical cannabis cultivation by March 1, 2016.

Banning medical marijuana cultivation and distribution will only impact the neediest patients, and drive the market towards underground, unregulated players, without allowing locals to recoup tax revenues (something that is specifically allowed under a MMRSA "clean up" bill that has also been introduced, AB 1575, which states "*The fees established by licensing authorities pursuant to this chapter shall be in addition to, and shall not limit, any fees or taxes imposed by a city, county, or city and county in which the licensee operates.")*

Submitted by:

Damian Martin
LA NORML

Ellen Komp
California NORML

Antoinette Mann - Fwd: Please Delay Any Action on Item 8A on the 1/12/2016 Agenda

From: Tracy Noonan <tnoonan@toaks.org>
To: Antoinette Mann
Date: 1/12/2016 10:39 AM
Subject: Fwd: Please Delay Any Action on Item 8A on the 1/12/2016 Agenda
Cc: Scott Mitnick; Andrew Powers; Geoff Ware; Patrick Hehir

Additional correspondence for supplemental packet. This was received by the Mayor and forwarded to me.

Sent from my iPad

Begin forwarded message:

From: "Joel Price" <jprice@toaks.org>
Date: January 12, 2016 at 10:37:06 AM PST
To: "Tracy Noonan" <TNoonan@toaks.org>
Subject: Fwd: Please Delay Any Action on Item 8A on the 1/12/2016 Agenda

FYI

Sent from my iPad

Begin forwarded message:

From: "Sarah Armstrong" <industry@safeaccessnow.org>
Date: January 12, 2016 at 12:17:43 AM PST
To: "Joel Price" <JPrice@toaks.org>, "Rob McCoy" <RMcCoy@toaks.org>, "" <cnclmanfox@aol.com>, "" <Albertcadam@gmail.com>, "" <claudia4slowgrowth@roadrunner.com>
Subject: Please Delay Any Action on Item 8A on the 1/12/2016 Agenda

To: The Honorable Members of the Thousand Oaks City Council
From: Sarah Armstrong JD
Director of Industry Affairs
Americans for Safe Access

Re: Proposed Medical Marijuana Ban – Agenda Item 8A on the January 12, 2016 Agenda
Request to Delay the Vote

TO COUNCIL 1-12-2016
AGENDA ITEM NO. 8.A.
MEETING DATE 1-12-2016

Date: January 11, 2016

Dear Honorable Members of the Thousand Oaks City Council:

We are writing today to urge you to delay any action on Agenda Item 8A on the January 12, 2016 agenda for the reasons listed below.

The first and most important reason to delay is that you have not had any input from those most affected by your decision, the sick and dying in your community. These vulnerable patients will suffer greatly if you cut-off all safe access to medical marijuana. The compassionate thing to do would be to consult with them and find some middle ground between their needs and those of the larger population before taking hasty hurtful actions which, because of their infirmities, the sick and dying are powerless to oppose. While I realize that you properly noticed all meetings, it is difficult for the average person to keep track of such things, and someone who is sick may have even more difficulties. Won't you consider having a town hall meeting so that patients and their caregivers might express their opinions before you ban?

Millions of people are finding relief using cannabis treatments for an array of medical conditions and symptoms. Currently, two-thirds of the population of the United States lives in states with medical cannabis laws, and over 2 million Americans currently use medical cannabis as a treatment option.
A recent, wide-ranging survey in California finds that 92 percent of the medical cannabis patients surveyed said that medical marijuana alleviated symptoms of their serious medical conditions, including chronic pain, arthritis, migraines, and cancer.

This data originates from the California Behavioral Risk Factor Surveillance System, a representative health survey of 7,525 California adults produced by the Public Health Institute in partnership with the CDC.
A link to the survey can be found at:
http://www.ncbi.nlm.nih.gov/pubmed/25255903
A link to the table showing the results of the survey can be found here:
https://www.washingtonpost.com/news/wonk/wp/2014/10/01/92-of-patients-say-medical-marijuana-works/

Recent Developments at the State Level Have Removed the Urgency to Legislate Before March 1, 2016. Localities Can Now Take the Time To Legislate Compassionately, Rather Than Rushing to Ban

The last League of Cities Letter sent to you is dated January 5th. Thus, it could not have contained the following information which took place after the letter was generated: AB 21 has completed its third reading in the Senate, passed out of the Rules Committee and moved simultaneously to its last two committees. It will be heard in both committees on Wednesday, January 12th, and is expected to pass. Wood stated in a Los Angeles Times article that he expected to have the bill become law by March 1st. The author of the Los Angeles Times Article confirmed that Governor Brown would sign the bill. You can link to the Los Angeles Times article here: http://www.latimes.com/politics/la-me-pol-sac-1219-pot-deadline-story.html

As a practical matter, municipalities need not fear that the Department of Agriculture will begin issuing licenses by March 1st. The mechanism to do so is not in place, and will not be operational until January 1, 2018, which is the date set to actually begin issuing licenses. Extensive rules promulgation has to take place before licensing can begin which may delay things even further. At this point, it is impossible for a cultivation or any other license to be issued as the application forms do not exist, the amount to be charged for an application has not been set, and there are no personnel designated to process or issue licenses.

Changes in Federal Law Now Allow Localities To Enact Local Medical Marijuana Laws Without Fear of Violating the Federal Controlled Substances Act (CSA)

In 2015, an Act of Congress, (for the second year in a row) comprehensively revised the federal government's stance on medical marijuana programs and the patients and patient providers who participate in them.

Per the Farr-Rohrabacher amendment in the 2016 Omnibus Appropriations Bill (see: Section 542 Page 223 of the bill) the Department of Justice is now barred from interfering with state medical marijuana laws and programs. The amendment enjoyed wide bi-partisan support and is likely to be included in the Appropriations Bill each year.[1]

To ensure the Department of Justice follows this mandate, the

amendment prohibits the Department of Justice from expending any funds to enforce federal laws against the use, distribution, possession or cultivation of medical marijuana in States which have medical marijuana programs. This is appropriate, as 80% of the states now have laws recognizing the use of medical marijuana in some form or another.

Moreover, to clarify that this amendment was meant to protect both medical marijuana patients and those operating businesses lawfully supplying medical marijuana and medical marijuana products to patients, the two authors of the amendment wrote a strongly worded letter to Attorney General Eric Holder which said in part:

"... 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 closing we respectfully insist that you bring your Department back into compliance with federal law by ceasing marijuana prosecutions and forfeiture actions against those acting in accordance with state medical marijuana laws."

Earlier in the year, Representatives Farr and Rohrabacher, furious that the Department of Justice insisted on interpreting the amendment as applying only to the State Medical Marijuana programs but not to the patients or patient providers protected under those laws, called for an investigation of the Justice Department in a letter to the Inspector General which read in part:

"... We, the authors of the language, and our many colleagues – including those who opposed the amendment – laid on the record repeatedly that the intent and the language of the provision was to stop the DOJ from interacting with anyone legitimately doing business in medical marijuana in accordance with state law... Any official of the Department who interprets Section 538 differently, is doing so knowingly and willfully, without regard for the facts."

On October 19, 2015 the federal court for the Northern District of California decided, in a case entitled U.S. v Marin Alliance for Medical Marijuana (Case No. C-98-00086CRB) that the federal government could not interfere with medical marijuana patients and providers who were acting legally under state medical

marijuana laws.

As the language of the Rohrabacher-Farr Amendment expressly prohibits the Department of Justice from expending any funds to enforce laws that interfere with a State's ability to implement its own medical marijuana program, the Court held that the Department of Justice could only enforce the Federal Controlled Substances Act to the extent that a medical marijuana business is not in full compliance with "state law that authorizes the use, distribution, possession, or cultivation of medical marijuana."

In other words, federal policy as put forth by the United States Congress no longer allows enforcement of the Federal CSA against all users and providers of marijuana. It now allows enforcement only against those who are NOT medical marijuana patients or medical marijuana providers complying with state medical marijuana laws.

This stunning reversal of policy means that the stated reason for banning marijuana businesses in Oxnard is now moot, and we respectfully urge the City of Oxnard to revise its medical marijuana policies rather than instituting a ban.

Failure to Make a CEQA Determination Before Banning May Result in Litigation

A Los Angeles dispensary operator, James Shaw, has serially sued, or threatened to sue, municipalities that failed to conduct a CEQA review before banning or authorizing dispensaries. He sued and then withdrew his suit in Los Angeles, sued in San Diego and in December of 2013 sent a letter to the City of Ventura threatening to sue them over their proposed ban. To avoid this nuisance litigation you might consider delaying a vote until a CEQA review can be done.

See the following links for news stories about this phenomenon:
http://www.prnewswire.com/news-releases/city-of-la-failed-to-do-environmental-impact-report-for-its-medical-marijuana-ordinance-129409268.html
http://www.allgov.com/usa/ca/news/controversies/marijuana-advocates-claim-san-diego-limits-on-pot-shops-will-cause-pollution-140505?news=853074
http://clkrep.lacity.org/onlinedocs/2008/08-0923-S7_pc_1-14-11.pdf

The Right of Patients to Associate Collectively or

Cooperatively to Cultivate Is Still The Law and Will Remain So Until State Licenses Begin Issuance.

See AB 266 which states:

"Section 11362.775 of the Health and Safety Code is amended to read:

11362.775.

(a) Subject to subdivision (b), qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, who associate within the State of California in order collectively or cooperatively to cultivate cannabis for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570.

(b) This section shall remain in effect only until one year after the Bureau of Medical Marijuana Regulation posts a notice on its Internet Web site that the licensing authorities have commenced issuing licenses pursuant to the Medical Marijuana Regulation and Safety Act (Chapter 3.5 (commencing with Section 19300) of Division 8 of the Business and Professions Code), and is repealed upon issuance of licenses"

As state law is sovereign you might want to think about regulating the time, place and manner of personal grows rather than outlawing them.

Simply Banning Makes You Vulnerable to a Voter Initiative Run by Outsiders Who Have Only A Profit Motive.

This has already almost happened, in January of last year Precision Politics attempted to mount a voter initiative in Oxnard. Forcing small towns to implement safe access via voter initiatives is getting to be an increasingly popular ploy, one made impossible if you regulate sensibly rather than ban. Signal Hill, a tiny town near Long Beach is the latest target of these kinds of efforts. You can read about their situation at:
http://www.presstelegram.com/health/20160108/medical-marijuana-supporters-in-signal-hill-begin-collecting-signatures-for-ballot-measure

Taken altogether, the arguments above would allow you to refrain from taking any action until you'd had time to meet with patients and craft compassionate medical marijuana policies. The sick and dying in your community need your assistance, not your dismissal. Small towns across the State have crafted ordinances

that work well for them. Sebastopol, West Hollywood and Palm Springs are a few examples of this and I'm confident Oxnard can craft a sensible ordinance as well.

If you have any questions or concerns, I can be reached at (805) 279-8229 or Industry@safeaccessnow.org.

Respectfully submitted,
Sarah Armstrong JD
Director of Industry Affairs
Americans for Safe Access

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[1] The Rohrabacher-Farr amendment passed in the House by a vote of 242-116 and the Senate Appropriations Committee approved it 21-9.

Antoinette Mann - Fwd: URGENT! Permission of the Secretary of Food and Agriculture Now Required to Ban Medical Marijuana Cultivation Per A New 2015 Law

From: Tracy Noonan <tnoonan@toaks.org>
To: Antoinette Mann
Date: 1/12/2016 10:40 AM
Subject: Fwd: URGENT! Permission of the Secretary of Food and Agriculture Now Required to Ban Medical Marijuana Cultivation Per A New 2015 Law
Cc: Scott Mitnick; Andrew Powers; Patrick Hehir; Geoff Ware

More correspondence for supplemental packet forwarded to me by the Mayor.

Sent from my iPad

Begin forwarded message:

From: "Joel Price" <jprice@toaks.org>
Date: January 12, 2016 at 10:37:26 AM PST
To: "Tracy Noonan" <TNoonan@toaks.org>
Subject: Fwd: URGENT! Permission of the Secretary of Food and Agriculture Now Required to Ban Medical Marijuana Cultivation Per A New 2015 Law

FYI

Sent from my iPad

Begin forwarded message:

From: "Sarah Armstrong" <industry@safeaccessnow.org>
Date: January 12, 2016 at 12:07:02 AM PST
To: "Joel Price" <JPrice@toaks.org>, "Rob McCoy" <RMcCoy@toaks.org>, "" <cnclmanfox@aol.com>, "" <Albertcadam@gmail.com>, "" <claudia4slowgrowth@roadrunner.com>
Subject: URGENT! Permission of the Secretary of Food and Agriculture Now Required to Ban Medical Marijuana Cultivation Per A New 2015 Law

To: The Honorable Members of the Thousand Oaks City Council
From: Sarah Armstrong JD
Director of Industry Affairs
Americans for Safe Access
Date: January 11, 2016

TO COUNCIL 1-12-2016
AGENDA ITEM NO. 8.A.
MEETING DATE 1-12-2016

On December 20th, I wrote to you, informing you that emergency legislation was being pushed through by Assemblyman Wood's office to remove the March 1, 2016 deadline by which municipalities had to regulate medical marijuana cultivation. The bill has now had its third reading and will be heard in its final two committees on Wednesday. Assemblyman Wood still expects to have the bill sgned by the Governor by March 1st.

In the meantime, another development has surfaced. As you can see below, you cannot ban medical marijuana cultivation without the permission of the Secretary of Food and Agriculture. The reason for this, is that in the Medical Marijuana Regulation and Safety Act, medical marijuana is classified as an agricultural product. Please have your legal counsel review the code section below before you ban, as I'm sure you would not wish to violate the laws of the State of California.

The Banning of Medical Marijuana Cultivation Now Requires the Permission of the Secretary of Food and Agriculture

In 2015, Section 4 paragraph 52334 of the California Food and Agriculture Code was added and reads:

52334. Notwithstanding any other law, on and after January 1, 2015, a city, county, or district, including a charter city or county, shall not adopt or enforce an ordinance that regulates plants, crops, or seeds without the consent of the secretary. An ordinance enacted before January 1, 2015, shall be considered part of the comprehensive program of the department and shall be enforceable.

Respectfully submitted,
Sarah Armstrong JD
Director of Industry Affairs
Americans for Safe Access

City of Thousand Oaks

Public Works Department
MEMORANDUM

2100 Thousand Oaks Boulevard • Thousand Oaks, CA 91362
Phone 805/449.2400 • Fax 805/449.2475 • www.toaks.org

TO: Scott Mitnick, City Manager

FROM: Jay T. Spurgin, Public Works Director

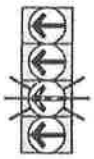
DATE: January 12, 2016

SUBJECT: **Flashing Yellow Arrow Left-Turn Operations at Traffic Signals (CI 5259) – Item 9.C**

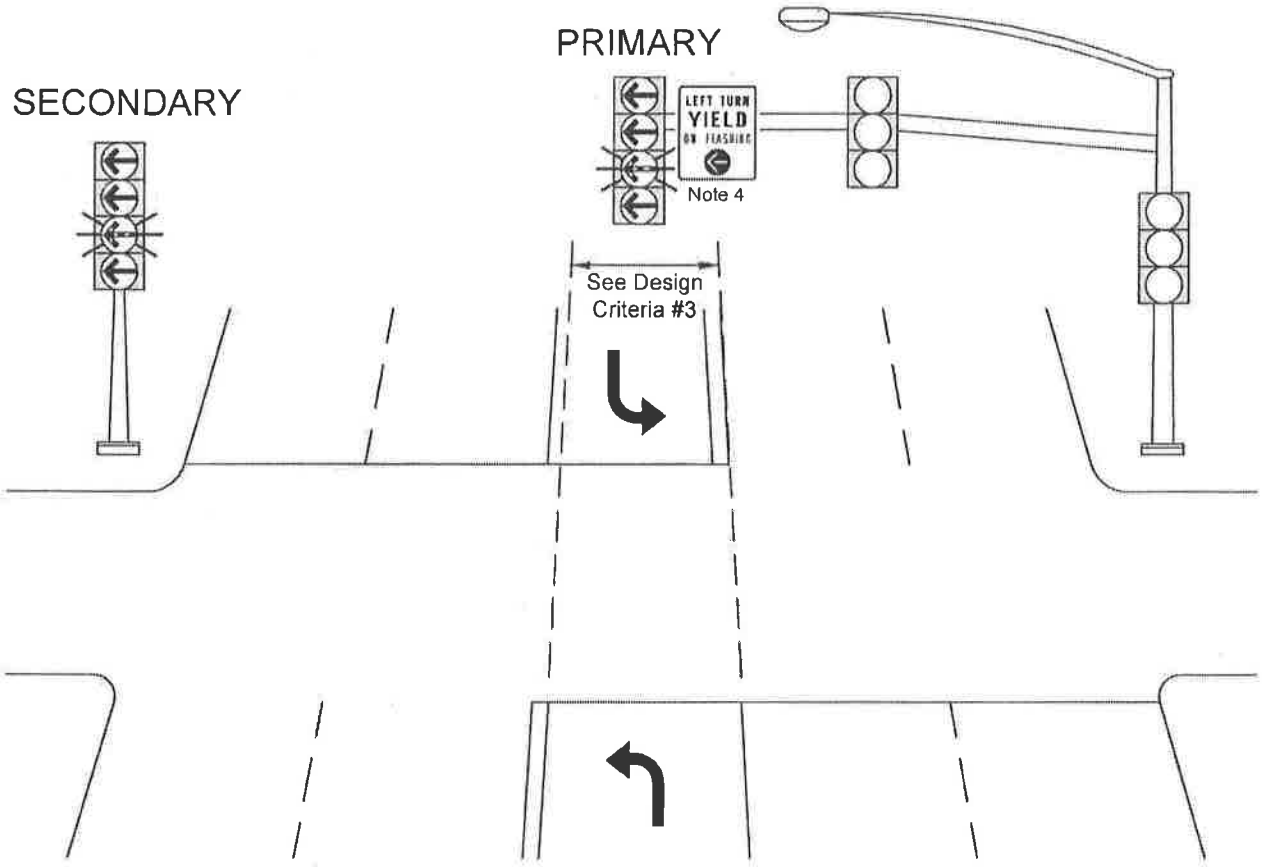
Please replace Attachment #4 - City of Thousand Oaks Road Design and Construction Design Standard Plate 7-15 with attached.

TO COUNCIL 1-12-2016
AGENDA ITEM NO. 9.C.
MEETING DATE 1-12-2016

DPW: 821-30\etm\Council\011216\Flashing Yellow Arrow green packet



Steady Red Arrow - Drivers turning left must stop and wait (except where permitted by law)
Steady Yellow Arrow - Stop, if you can do so safely
Flashing Yellow Arrow - Proceed with left turn after yielding to oncoming traffic and pedestrians
Steady Green Arrow - Proceed with left turn



DESIGN CRITERIA:

1. Shall conform to CA MUTCD 2014, Section 4D.20
2. Stopping sight distance should meet AASHTO Exhibit 3 - 1
3. Primary Signal Head must be positioned within the channelizing lines of the left turn pocket
4. Speed Limit of traffic should be ≤ 45 MPH
5. Number of opposing thru lanes shall be ≤ 3

NOTES:

1. Cannot be implemented where Dual or Triple Left turn lanes exist
2. Cannot be implemented if traffic signal has split phased operation
3. If cross product (Left Turn Volume x Opposing Thru Volume) is greater than 100,000 during any one hour period, then protected only phasing should be considered for that one hour period
4. Sign - "Left Turn Yield on Flashing" - Yellow Arrow Symbol, minimum size 24"x30"
   White - Background Black - Letters Yellow - Arrow Symbol

CHG	DESCRIPTION	DATE	INITIAL

CITY OF THOUSAND OAKS
PUBLIC WORKS DEPARTMENT

APPROVED _____ CITY ENGINEER _____ DATE

STANDARD INSTALLATION
OF FLASHING YELLOW ARROW
PROTECTED / PERMISSIVE
TRAFFIC SIGNAL

PLATE NO
7-15