

Recommendations for Preserving Patient Rights in Washington State *Comments on the Draft Recommendations of the Medical Marijuana Work Group*

Submitted by Americans for Safe Access
November 7, 2013

What follows is the response of Americans for Safe Access, a national patient advocacy organization with more than 50,000 members, to the draft recommendations of the Washington State Work Group on Medical Marijuana, which was comprised of representatives from the Washington State Department of Revenue, Department of Health, and Liquor Control Board. The comments and responses below are to assist the Washington State Liquor Control Board in finalizing recommendations for submission to the state legislature.

Shortly after the Work Group released their draft recommendations for integrating the state's existing medical cannabis program, established by voters in 1998, with the new adult-access retail model approved by voters last November as I-502, Americans for Safe Access (ASA) conducted a series of meetings with the state's medical cannabis stakeholders to gather feedback on how the proposals would affect patient access.

Between October 27 and 30, ASA held public stakeholder meetings in Olympia, Seattle, Bellingham, Yakima and Spokane. Outreach for these meetings was conducted through Facebook, emails to ASA members, and press coverage. Meeting attendees were mostly self-identified patients and their loved ones, but identified caregivers, collective garden members, access point operators and medical professionals were also represented. Of the more than 150 attendees at the five Washington stakeholder meetings, about two-thirds signed in; those 108 individuals represented 74 zip codes in the state:

98003, 98008, 98026, 98027, 98030, 98032, 98034, 98040, 98042,
98045, 98070, 98071, 98101, 98105, 98106, 98107, 98108, 98112,
98116, 98117, 98118, 98121, 98122, 98125, 98133, 98136, 98144,
98155, 98198, 98203, 98208, 98229, 98230, 98237, 98270, 98273,
98275, 98282, 98290, 98329, 98444, 98446, 98501, 98502, 98503,
98509, 98516, 98520, 98524, 98528, 98535, 98584, 98586, 98597,
98597, 98611, 98901, 98902, 98908, 98936, 98937, 98942, 99009,
99102, 99111, 99114, 99204, 99205, 99206, 99207, 99208, 99223,
99224

The comments below reflect the detailed responses of stakeholders who attend the meetings and the considered opinion of ASA staff based on a decade of experience

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working with both medical cannabis stakeholders and state and local officials to implement effective regulations that ensure compassionate access and accommodate community concerns.

The meetings began by reading the entirety of the Working Group's recommendations for changes to Washington's medical cannabis program. The groups went through each section and were first asked what they liked about the section. The overall sentiment was that the Working Group's recommendations minimize the differences between medical users and general consumers, fail to consider the needs of patients with the most serious conditions, and, if implemented, would dismantle a functioning medical cannabis program, denying adequate care to those who need it most.

1. Washington Work Group recommendation: Age limits

- Adults 18 to 20 years old should be allowed access to medical marijuana with proper authorization from a health care professional.
- Children 17 years old or younger should be allowed access to medical marijuana with parent or guardian consent to the authorization. The parent or guardian should participate in the child's treatment.
- Authorizing health care professionals should be required to engage in frequent re-examination and follow-up with a child patient and communication with the parent or guardian. The authorizing health care professional should also be required to consult with other health care providers involved in the child's treatment before authorization or reauthorization of medical marijuana.
- The child's parent or guardian should be required to act as the child's designated provider and be entered in the registry as such.
- The parent or guardian should have sole control over the child's medical marijuana. The child should be allowed to possess no more medical marijuana than necessary for his or her next dose.
- Medical marijuana consumed in a school setting should be held and administered by school personnel in the same manner as any other medication. Consistent with current law, schools should not be compelled to accommodate on-site use of medical marijuana on school grounds or school buses.
- Medical marijuana products should be prohibited from being labeled in a manner that mimics candy, soda or other treats attractive to children.

Under I-502:

A person must be 21 years old to legally possess marijuana, to hold a marijuana license or enter a licensed marijuana premise.

ASA comments on age limits

A. Stakeholder input: Overall consensus of the stakeholder groups were that this section was acceptable. There was some concern about the definition of "frequent examination" and "consult with other health care providers," as well as access to medicine at school that is "consistent with current laws." However, it was the overall consensus that, if the definitions mirrored the requirements for other medical treatment for minors and were not used to overburden guardians or interpreted punitively to deny recommended treatment,

these qualifications would also be acceptable. Concerns about a mandatory registry also came up in discussion of this recommendation , which is covered in the next section.

B. ASA’s Recommendation: Generally speaking, the recommendations of the Liquor Control Board (LCB) on age limits are acceptable, although ASA shares the concerns of stakeholders. The term “frequent examination” is vague and therefore must be defined in a way that does not make it prohibitive for parents to meet the standard. For example, low-income or single parents may have a more difficult time taking their child to the doctor frequently. Additionally, it is an unnecessary burden to compel physicians to consult with other medical professionals prior to recommending or renewing a recommendation. In fact, New Jersey recently removed a similar requirement as needlessly burdensome. ASA approves of the LCB recommendations that would allow school nurses to store and administer a student's medical cannabis, but agrees with stakeholders that rules should not be drafted in a way that encourage school staff to stand between a youth patient's medical well being and education. For example, if a school nurse refuses to participate in the administration of a child's medical cannabis, the rules should allow other school personnel or adult volunteers to do so.

2. Washington Work Group recommendation: Authorizing requirement for medical marijuana

- A mandatory patient and designated provider registry should be established and maintained by the Department of Health.
- The registry should be mandatory for all patients as a condition of receiving an authorization.
- The registry should be used to determine eligibility for exemption from state and local retail sales and use taxes on marijuana purchases by qualified patients.
- Designated providers should be required to participate in the registry in conjunction with the patient.
- Patient and designated provider information should be entered into the registry by the authorizing health care professional. The information must contain sufficient unique identifiers (Washington driver's license or identification card number or social security number) to ensure accurate identification of the patient or designated provider.
- Registration should expire annually and the patient or designated provider may be re-entered in the registry only after a new or follow-up examination.
- Cards should be issued from the registry to identify patients and designated providers.
- The registry should be available to law enforcement and to the Department of Revenue as necessary to verify tax-exempt purchases under Title 82 RCW.
- Disciplining authorities for the health care professions allowed to authorize medical marijuana should have access to the registry to monitor compliance by their licensees.
- Consistent and reliable funding must be provided to establish and maintain the registry.

- The registry should contain sufficient security features to protect patient privacy. Information in the registry that could identify patients should be excluded from public disclosure.
- All existing authorizations should expire on a date certain to coincide with full implementation of the registry and retail market. All patients with existing authorizations would need to be re-evaluated by a health care professional pursuant to the revised standards and placed in the registry within a designated timeframe.

Under 1-502:

N/A

ASA comments on authorizing requirement for medical marijuana

A. Stakeholder input: The consensus of all stakeholder groups was that this section, if implemented, would put patients at unnecessary risk. As it stands, in the state of Washington, anyone 21 years or older can possess cannabis without providing personal information to a registry. The only benefits accruing from this section, as written, would be relief for patients from the final stage of the new cannabis tax structure, access to cannabis for minors, and a concession on the allowable amount that can be purchased in a I-502 authorized store. Every stakeholder group voiced concerns about access to private health records being provided to federal agencies, local and state law enforcement, Department of Motor Vehicles and Child Protective Services. Some attendees were open to a verification system between patients, health care professionals and access points, as long as it was handled by an independent, third-party vendor that does not include law enforcement or a government agency.

B. ASA's Recommendation: Mandatory registration of patients is unnecessary, and instead ASA recommends a voluntary registry. The necessary purposes that are served by creating a mandatory registry can also be accomplished by voluntary registry, as has been the case with the Maine Medical Use of Marijuana Program. ASA shares the concern that a mandatory registry will put patients at risk for harm and harassment.

Maine has accomplished this by requiring that physician recommendation forms be on a tamper-proof form provided by the state. A completed form serves at the patient's authorization to purchase, possess and use medical cannabis, eliminating the need for law enforcement to run registration ID card checks. Instead, they simply need to verify the authenticity of the form. This has not been an issue for Maine law enforcement, nor has it harmed the public safety of the state. Only patients with valid recommendation forms would be allowed to purchase medicine; caregivers would still be required to register. This system best protects the privacy and safety of patients while achieving the necessary goals of a registry. The legislation that ASA has proposed contains a provision for the creation of a workgroup of at least 12 medical cannabis stakeholders will be appointed by the state legislature to study the potential benefits and drawbacks of a voluntary patient registry or uniform identification system. The text of the Maine legislation establishing the state's voluntary registry is attached following the comments.

3. Washington Work Group recommendation: Regulations regarding healthcare professionals

- Define "debilitating" and "intractable pain" to clearly indicate the condition must be severe enough to significantly interfere with the patient's activities of daily living and ability to function, and can be objectively assessed and evaluated.
- Enact comprehensive requirements defining the standard of care for health care professionals who authorize medical marijuana similar to those required by ESHB 2876 (201 0) regarding the use of opioids to manage chronic pain. The requirements should address topics such as adequacy of examination, follow-up care and recording keeping.
- Restrict a health care professional's practice to ensure it does not consist primarily of authorizing medical marijuana.
- Require a permanent physical location for a health care professional's place of practice.
- Require in person examinations for authorizations.
- Require an expiration of authorizations to ensure a regular cycle of re-examination and follow-up care.
- Eliminate the provision allowing for petitions to add qualifying conditions. Patients with conditions other than those already authorized can follow the legislative process to change the law and can avail themselves of the recreational marijuana market until such time as the law is changed. In the alternative, amend the petition provision to allow the Medical Quality Assurance Commission to make a preliminary finding of good cause prior to holding a hearing and expand the time frame for the hearing to be completed.

Under I-502:

N/A

ASA comments on regulations regarding healthcare professionals

A. Stakeholder input: The consensus of all the stakeholder groups was that this section, if implemented, would create unnecessary barriers without additional benefit because the state of Washington already has an oversight system in place through the Department of Health (DOH) to regulate health care professionals. The consensus was that existing professional practice standards and enforcement by DOH are sufficient to protect community interests without additional restrictions from the legislature.. However, the groups were open to CME courses on the medical use of cannabis being offered to health care professionals by DOH in conjunction with the Medical Quality Assurance Commission (MQAC).

B. ASA's Recommendation: ASA agrees with stakeholders that the LCB's recommendations for medical professionals are unnecessary and burdensome and could result in patients being denied care. Healthcare professionals are already supervised by the Washington State Medical Quality Assurance Commission. Imposing stricter definitions on qualifying conditions would inhibit the ability of physicians to exercise their trained, professional judgment in treating individual patients. Requiring physician appointments to take place at a doctor's office could prevent non-ambulatory patients

from receiving care. Harmful unintended consequences such as these flow from other LTC recommendations, as well.

Ever since the Clinton Administration threatened to strip the prescribing licenses of doctors who discussed medical cannabis with their patients, many physicians have resisted writing recommendations for their patients out of fear of retribution. The LCB proposal to restrict valid recommendations to those from a physician whose practice does not consist primarily of authorizing medical cannabis therapy ignores the benefits patients derive from seeing physicians with specialized training and knowledge and could have a chilling effect that results in fewer physicians being willing to write even a single recommendation. Reducing the number of physicians who are willing to write recommendations is worse than unintended consequence; it can have the opposite of the intended effect, as patients are forced to seek the few participating practices, concentrating medical cannabis recommendations to fewer physicians. This has been the experience in Colorado, where a similar imposition on physician's practices is in place. The LCB recommendation to void existing recommendations and require new patient authorizations will create an annual bottleneck and place an annual burden on both patients and the reduced number of physicians willing to write recommendations. Artificially limiting the pool of qualifying doctors and forcing patients to renew at the same time each year creates needlessly burdens and barriers without clear community benefit.

ASA recommends that none of the LCB recommendations on medical professionals be adopted. Furthermore, the public petitions process for adding new qualifying conditions should only be discarded in the context of granting physicians the right to freely exercise their professional judgment in determining what conditions and which patients may benefit from medical cannabis therapy.

4. Washington Work Group recommendation: Collective Gardens

- Eliminate Collective Gardens.

Under I-502:

N/A

ASA comments on collective gardens

A. Stakeholder input: The consensus of all the stakeholder groups was that this section, if implemented, would remove patient rights critical to the well being of the most needy. Washington law has guidelines for collective gardens, and it is the consensus of all groups that those rules should remain intact and enforced. Attendees strongly believe that eliminating collective gardens will drive up the price of their medicine, restrict access to specialty medical strains, and degrade the quality of care. In particular, the groups voiced concern about losing access to recently developed medicinal varieties such as those that have chemical profiles that are more powerfully anti-inflammatory and anti-spasmodic than they are intoxicating. Concerns were also raised about access for patients on limited incomes and for those who live in rural areas and have limited mobility. The

overall consensus was that medical patients cannot be served adequately if their only access is commercial stores.

B. ASA's Recommendation: ASA recommends that the current law for collective gardens be preserved. The right to cultivate medicine is essential for ensuring that patients have the proper variety of strains available, as high-CBD, low-THC strains of medical cannabis are difficult to obtain and may not be available from retail marijuana stores under I-502. State officials should also note that personal cultivation by patients and caregivers is the sole method of providing medical cannabis that the federal government has consistently said is not an enforcement concern.

5. Washington Work Group recommendation: Possession Amounts

- Reduce the amount a qualified patient or designated provider can possess at any given time from twenty-four ounces of useable marijuana (a sixty day supply) to three ounces (a one week supply).
- Allow additional limits for marijuana infused products in solid or liquid form.
- Eliminate home grows and the ability for a qualified patient or designated provider to possess marijuana plants in any stage of growth. Define "plant" to avoid any misconstruction of this provision.
- Eliminate the ability for designated providers to also be qualified patients and thus possess double the legal limit of medical marijuana.
- Require labeling to include the levels of tetrahydrocannabinol (THC) and cannabinoids in medical marijuana products.
- Restrict labeling and marketing of medical marijuana products to ensure that they are not intentionally attractive to minors or recreational users.
- Eliminate the provision in RCW 69.51 A. 045 that grants qualified patients or designated providers an affirmative defense to criminal charges of possession above the legal amount if they can prove at trial the patient's necessary medical use exceeds the amount determined in law.

Under I-502:

One ounce of useable marijuana; 16 ounces of marijuana infused product in solid form; or 72 ounces of marijuana infused product in liquid form.

ASA comments on possession limits

A. Stakeholder input: The consensus of all stakeholder groups was that this section, if implemented, would prevent patients from maintaining an adequate supply of medicine, potentially impose financial hardship on patients or prevent access, and risk the loss of specialty medical varieties, as described above. While the requirement on labeling was generally welcomed, there was consensus that this section, taken as a whole, would strip fundamental, voter-approved rights from patients and create barriers and hardship for the most needy.

B. ASA's Recommendation: Labeling requirements are sensible, provide important information for patients, and help maintain the integrity of the program. ASA's analysis of the reduction in possession amounts for patients and ban on cultivation reaches the

same conclusion as that of Washington stakeholders. Reducing the possession amount by 87.5% and banning cultivation would substantially harm those patients on limited incomes and with the most serious conditions who typically need large quantities of medical cannabis. Washington should maintain the current possession amounts and cultivation rights. This, coupled with the elimination of the affirmative defense for amounts above the possession limit, would put some of the state's most vulnerable patients at substantial risk.

State officials should again note that personal cultivation by patients and caregivers is the sole method of providing medical cannabis that the federal government has consistently said is not an enforcement concern.

6. Washington Work Group recommendation: Location Requirements

- Not applicable because only current I-502 licensed retail stores may sell marijuana and accept medical marijuana authorization cards.

Under I-502: Medical marijuana licensed business cannot be within one thousand feet of the perimeter of the grounds of any of the following entities:

1. Elementary or secondary school;
2. Playground;
3. Recreational center or facility;
4. Child care center;
5. Public park;
6. Public transit center;
7. Library; or
8. Any game arcade where admission is not restricted to persons age 21 or older.

ASA comments on location requirements

A. Stakeholder input: The consensus of all stakeholder groups was that forcing patients into a 502 retail system is unworkable for the reasons stated above and others, such as the prohibition on retail store employees discussing potential therapeutic benefits of particular strains or cannabis products.

B. ASA's Recommendation: Patients need a distribution system of storefront locations that is separate from the I-502 retail marijuana shops. ASA has worked with local stakeholders to develop a legislative proposal that would create such a system based on SB 5073, the medical cannabis bill passed by the legislature in 2011 and then partially vetoed because of federal threats. ASA's proposed legislation includes 1,000-foot distance requirements from schools and parks and allows municipal governments to enact additional zoning laws.

7. Washington Work Group recommendation: Requirements for medical marijuana processing, producing and retail licensing

- A single system for medical and recreational producer and processor licenses. Only recreational marijuana stores with an endorsement may accept medical marijuana authorization cards. Make the new regulatory system for medical marijuana effective no sooner than January 1 , 2015.

Under I-502:

1. Three separate license tiers: producer, processor and retailer;
2. A licensee may hold both a producer and processor license simultaneously, but not a retailer license;
3. Open registration for all license types for a 30-day window;
4. Three month state residency requirement to qualify for a license;
5. Personal criminal history, fingerprint and background checks of applicants;
6. Point system for all arrests and/or convictions;
7. License limits;
8. Production limits; and
9. Maximum allowable amount of marijuana on licensed locations.

ASA comments on requirements for medical marijuana processing, producing and retail licensing

A. Stakeholder input: The consensus of all stakeholder groups was that forcing patients into a 502 retail system is unworkable for the reasons stated above.

B. ASA's Recommendation: Again, patients need a regulated storefront distribution system that is separate from the I-502 retail marijuana shops. The retail shops under I-502 are not well-suited for distributing medical cannabis to the complete spectrum of patients. While many patients may find it easier to locate and acquire common strains of cannabis, the adult-use market cannot be relied on to provide the necessary specialty strains some patients and conditions require. Instead of forcing patients into a retail market with other consumers, Washington should again adopt medical distribution regulations such as those passed in 2011 or the legislative proposal recommended by ASA.

8. Washington Work Group recommendation: Taxation of medical marijuana in relation to recreational marijuana

- Utilize the same tax structure as recreational marijuana, but provide an exemption from state and local retail sales and use taxes on purchases by medical marijuana patients registered with the Department of Health.

Under 1-502:

1. Producers
 - a. Pay 25% excise tax on wholesale sales
 - b. Pay B&O tax as wholesaler
2. Processors
 - a. Pay 25% excise tax on wholesale sales

- b. Pay B&O tax as manufacturer
- 3. Retailers
 - a. Pay 25% excise tax on retail sales
 - b. Pay B&O tax as retailer
 - c. Collect state/local retail sales & use tax
- 4. Retail Buyers
 - a. Pay state/local retail sales & use tax

ASA comments on taxation of medical marijuana in relation to recreational marijuana

A. Stakeholder input: The consensus of all stakeholder groups was that the tax structure present in the 502 licensing system would make medical cannabis unaffordable and inaccessible for most patients; simply exempting patients from sales tax will not be enough to alleviate the price burdens created by the multiple layers of excise taxes.

B. ASA's Recommendation: Patients should not be subject to burdensome taxes at the retail market. While the LCB does recommend that patients should be exempt from sales and use tax, they would still be subject to the steep 25% excise taxes applied at each stage from production to processing to retail. The legislative proposal recommended by ASA would create a parallel production and distribution system that would provide patients the same tax exemption for medical cannabis as that granted to herbal medicines and dietary supplements. Additionally, the legislative proposal would ensure that Washington medical cannabis patients are granted "the same rights and protections from civil and criminal liability as users of prescription drugs under Washington State law."

CONCLUSION

With exception to the section on age limits and recommendations for labeling, the Washington State Liquor Board should go back to the drawing board and produce recommendations that reflect the compassion for medical cannabis patients the state's voters demonstrated in 1998. State officials should not create additional barriers or hardship for Washingtonians who are already battling serious medical conditions.

Concern for the welfare of sick and disabled individuals can be accommodated while carefully regulating recreational users; the differing needs of the two groups just require different solutions. While the two markets could effectively share some of the same oversight as it relates to commercial cultivation, processing, testing and labeling requirements, the proposed distribution and taxation models cannot work as exclusive solutions for patient populations.

Claims about what portion of currently qualified medical cannabis patients may be classified as recreational users have no basis in fact. Much of this speculation is the result of observations made by unqualified individuals of the outward physical appearance of Washington's patient population. Basing access to health care on physical appearance is a form of discrimination in the view of ASA. Many diseases and conditions that can benefit from treatment with medical cannabis -- such as multiple sclerosis, neuropathic pain, and

gastrointestinal disorders -- do not produce symptoms that affect physical appearance. State officials should note there are laws in Washington that protect vulnerable populations from such discrimination.

Similarly, assumptions that Washington's current medical marijuana program will cut into potential tax revenues are based on speculation. There is strong sentiment among medical marijuana patients that, rather than targeting the medical cannabis program, officials should look at issues such as the illicit market and impact of the proposed tax structure to address revenue shortfalls.

Why pushing patients into the recreational market won't work

Population differences: The average medical cannabis patient uses 6 to 10 times more cannabis than the average recreational user. Furthermore, their use is one of need not want. Patients need access to a variety of strains and products for which there is no demand in the recreational market, such as low-THC varieties and topical treatments. **Innovation and science:** Much of what we know about the chemical compounds in cannabis and their effects on human systems has come from medical cannabis programs. In fact, a grant was recently awarded by Attorney General Bob Ferguson for researchers at the University of Washington to further study the benefits of medical cannabis in patient populations suffering from chronic pain. Dismantling Washington's medical cannabis program will place unnecessary stumbling blocks in the path of cutting-edge research.

Cost: Currently, insurance companies do not cover medical cannabis. With the patient population largely paying out of pocket for access to medicine, the cost of typical treatment options would be out of reach in a recreational marketplace. Some patients have documented medicine needs of nine or more ounces a month, which would mean out-of-pocket medication costs of more than \$45,000 per year at estimated retail prices. **Limitations on medical information:** Under current proposed rules pertaining to 502 retail outlets, cannabis cannot be marketed or sold in a manner that discloses the benefits in treating certain medical conditions. In these stores, employees will be strictly prohibited from helping a patient who is unfamiliar with medical cannabis discern which varieties or particular products are most beneficial for the treatment of their specific condition. **Taxation:** The proposed recommendations for taxes would mean that medical cannabis patients would be the only patients in the state of Washington subject to special taxes for their medicine. From a regulatory standpoint, it would certainly be easier for the state to have a single set of taxes for the production of marijuana, but simplicity of regulation should not trump the best interests of patients when it would not be difficult for the state to do so. Patients should be subject to neither sales and use tax nor the retail excise tax of the I-502 market.

Since 2011, when then-Governor Christine Gregoire line-item vetoed provisions in Senate Bill 5073, which would have established a regulated system of distribution for medical cannabis, cities and counties have put in place piecemeal regulations on collective gardens, though authority to do so was not created under 5073. Instead, they

had the ability to regulate licensed dispensers, producers and processors, which cannot legally exist due to the veto of those provisions.

If the legislature restores the sections and definitions line-item vetoed from 5073 – with some revisions made necessary to accommodate the intent of 502 – the untaxed, unregulated medical market will be given the opportunity to satisfy the voters’ intent by becoming licensed businesses like every other legitimate store.

Voters never intended for 502 to supersede the medical marijuana initiative passed in 1998, and they never intended for medicine to be taxed out of existence. Governor Gregoire buckled under threats from the US Attorney, leaving us with the unsustainable mess we have today. Governor Inslee can do better than his predecessor by offering real solutions that actually work for patients.

Maine Rules on Tamper-Resistant Forms and Voluntary Registry

1.29 Physician's written certification. Physician's written certification or written certification means a document on tamper-resistant paper signed and dated by a physician that expires in one year. The expiration date is included on the issued written certification. The physician's written certification must state that in the physician's professional opinion a patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition.

1.38 Tamper-resistant paper. Tamper-resistant paper means paper that possesses an industry-recognized feature that prevents copying of the paper, erasure or modification of information on the paper and the use of counterfeit documentation. See 22 M.R.S.A. §2422 (13-A).

4.1 Voluntary patient registration: no fee. Registration is voluntary for qualifying patients who want to secure a department-issued registry identification card. There is no fee to register. The voluntary application process for a registry identification card is set out in Section 8 of these rules. Registration is also voluntary for homeless qualifying patients, minor qualifying patients and incapacitated adult qualifying patients.

4.1.1 Department to expunge patient's specific medical condition. On or before November 28, 2011, the department shall expunge all information in the records of the State's medical use of marijuana program indicating a patient's specific medical condition.

4.1.2 Eligible individuals may request removal from registry within 6 months after the effective date of these rules. Individuals who were cardholders on or before September 28, 2011 (effective date of Public Law 2011, chapter 407) may submit a written request to be removed from the MMMP registry and have all of their information expunged by the department.

4.1.2.1 A patient removed from the registry becomes a non-registered qualifying patient if all other requirements are met.

4.1.2.2 Expungement must be completed by the department within 60 days of receipt of a request from an eligible individual.

4.1.2.3 After the 6 month period, all new and remaining, non-expunged information must be retained by the State for 6 years.

4.1.3 Exception to expungement. The expungement provisions in Sections 4.1.1 and 4.1.2 of these rules do not apply to a record with respect to which there is a pending law enforcement investigation. See Public Law 2011, Chapter 407, Sec. C-1.

