

MEDICAL CANNABIS WORKING GROUP
REPORT TO THE HAWAII STATE LEGISLATURE

HONOLULU, HAWAII

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ACKNOWLEDGEMENTS

MAHALO TO:

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EXECUTIVE SUMMARY

The Medical Cannabis Working Group (“MCWG”) convened in October 2009 to conduct a study and make recommendations to the 2010 Hawai`i State Legislature to improve the state’s ten-year-old medical marijuana program.

The MCWG, tasked with completing the mission of Act 29, establishing the Medical Cannabis Task Force, which was enacted over a veto by Governor Lingle but never convened, examined current state statutes, state administrative rules, and all county policies and procedures relating to the medical marijuana program. Further, it examined issues and obstacles that qualifying patients, physicians, caregivers, and law enforcement officials have encountered with the medical marijuana program. MCWG also compared and contrasted Hawaii’s medical marijuana program with all other states’ medical marijuana programs.

Based on the results of its study and a public survey, MCWG recommends that the following immediate actions be taken by the Legislature to improve Hawaii’s medical cannabis program:

1. Create a distribution system so that patients do not need to resort to the black market to obtain their medicine;
2. Increase the allowable number of plants and the amount of usable cannabis to ensure that patients have an adequate supply of their medicine;
3. Allow caregivers to care for at least five patients to ensure that patients are assured of an adequate supply and a competent caregiver; and
4. Transfer medical marijuana program oversight from the Department of Public Safety – a law enforcement agency -- to the Department of Health.

Additionally, MCWG recommends that the Legislature take action to ensure that the program addresses patient needs such as enhanced confidentiality, presumptive eligibility, faster certification, and access to forms and other necessary documents on the program website.

MCWG also urges the Legislature to facilitate the development and implementation of policies and procedures to facilitate inter-island transport of medical cannabis, and direct the counties and relevant administrative agencies to educate law enforcement and public safety officers on the medical cannabis law as a whole.

Other recommendations address healthcare matters such as creating a protocol for adding new covered medical conditions; expediting coverage for hospice patients; and extending the validity of program certification for more than one year for patients with chronic conditions.

Finally, since not all of the problems with the program need to be addressed by legislative action, MCWG recommends that the Medical Cannabis Working Group be permanently convened to identify and help implement strategies, both legislative and administrative, to improve Hawaii’s program.

I. Introduction

A. Medical Cannabis History in Hawai`i

In April 2000, Hawai`i became the first state to permit medicinal use of marijuana¹ via an act of the state legislature. Governor Benjamin Cayetano signed Hawaii's Act 228 into law on June 15, 2000. The Department of Public Safety, the overseer of the program, approved administrative rules for the program's implementation in December 2000.² Since then, more than 5,700 patients have been registered under the law to use medical marijuana.

Since its inception in 2000, no changes have been made to the law. But as the number of patients grew and as more and more states enacted more comprehensive medical marijuana laws, it became increasingly evident that improvements to Hawaii's program were desperately needed. For the last several years there have been half a dozen or more bills introduced each legislative session to improve the program. Registered patients who had experienced the many problems with the current law first-hand spearheaded many of these proposals. In every session, however, the bills failed to pass one or both chambers. Incidents such as the Department of Public Safety's release of patient names and addresses to a Hilo newspaper in June 2008 helped spur the demands for change.³

In the 2008 session, after several bills proposing substantive changes to the program failed to pass, both Legislative chambers agreed on a bill to set up a task force to study the programs and make recommendations to improve it. Governor Lingle vetoed this measure, H.B. 2675, and though the House voted to override it, the Senate did not.⁴

B. 2009 Legislation and Gubernatorial Veto

Conflict between federal and state laws on medical cannabis had long been seen as an obstacle to any further refinements to the Hawai`i law. However, proponents for changing the law became emboldened with the 2009 election of President Obama and his administration.

Nonetheless, in the 2009 session, a scenario similar to 2008 played out again. A bill to establish a task force, S.B. 1058, passed and was again vetoed by Governor Lingle.⁵ The July 6, 2009 veto message stated in part: "[Act 29/S.B. 1058, C.D.1] sets up a Task Force on medical marijuana. Both the medical Cannabis task force and the salvia divinorum [a psychoactive herb] task force established under this measure will require significant financial resources and manpower from the Department of Public Safety, a department that must focus on running our correctional facilities and meeting its safety obligations. Until federal marijuana laws are changed, it is inappropriate for state law enforcement agencies to recommend ways to access, transport, or increase the use of marijuana."⁶

¹ In this report the terms "marijuana" and "cannabis" will be used interchangeably. "Marijuana" was used in the original legislation first introduced in 1999 and the existing program is known as the Hawai`i Medical Marijuana Program. However, it is now widely recognized that the scientific term "cannabis" (capitalized when referring to the specific genus) is preferable.

² See Appendix A for the text of Act 228, Chapter 2 of the Legislative Reference Bureau report and Appendix B for the Hawai`i Administrative Rules.

³ See Appendix C for DPS' letter to patients advising them of the release of their contact information.

⁴ See Appendix D for Governor Lingle's H.B. 2675 veto message.

⁵ See Appendix E for the text of Act 29.

⁶ See Appendix F for Governor Lingle's S.B. 1058 veto message.

While the Department of Public Safety is indeed tasked with running our prisons, that is not its sole mission. Its Narcotics Enforcement Division is also responsible for collecting fees from patients and administering the medical marijuana program.

On July 16, 2009, both chambers of the Hawai'i legislature voted to override the Governor's veto of S.B. 1058. In the Senate, the vote was unanimous. In the House, the vote to override the veto was 38 Ayes and 9 Noes. Despite this strong message from the legislators, Linda Smith, Governor Lingle's top policy advisor, responded to an inquiry from Senator Espero by email on September 2, 2009 and stated that the administration would not permit an official task force to convene. The email headed, "Inquiry regarding S.B. 1058," and read in full, "Senator: I understand you had inquired about the Medical Marijuana Task Force under S.B. 1058. It does not appear that we will be able to convene this Task Force between now and the end of the year. Should that change, I will be glad to notify your office."

C. Existing State Law Analysis

As noted earlier, Hawaii's medical cannabis law was the first to be passed legislatively, and several more states have authorized medical use of cannabis legislatively or by voter initiative since 2000.⁷ In October 2009, United States Attorney General Eric Holder issued new formal guidelines ordering federal authorities not to arrest or prosecute medical marijuana users and suppliers who aren't violating local laws.⁸ This change has paved the way for additional states to pass medical cannabis laws (*e.g.*, New Jersey in January 2009), so that there are now fourteen states that allow medical marijuana use.

This new Obama administration policy also served to encourage groups like MCWG to propose amendments to existing medical marijuana laws without fear of federal interference. The Congressional Research Service's March 2009 Report, "Medical Marijuana: Review and Analysis of Federal and State Policies," offers a comprehensive overview of some of the controversies surrounding medical marijuana (see below).⁹ Bear in mind, however, that this report was published before Attorney General Holder issued the new policy directives.

The issue before Congress is whether to continue the federal prosecution of medical marijuana patients and their providers, in accordance with the federal Controlled Substances Act (CSA), or whether to relax federal marijuana prohibition enough to permit the medicinal use of botanical cannabis products when recommended by a physician, especially where permitted under state law.

Bills that would make medical marijuana available under federal law for medical use in the states with medical marijuana programs and that would make it possible for defendants in federal court to reveal to juries that their

⁷ See Appendix G for state law excerpt taken from Eddy, Mark. *Medical Marijuana: Review and Analysis of Federal and State Policies*, 17-23 (March 31, 2009), available at <http://www.fas.org/sgp/crs/misc/RL33211.pdf>.

⁸ Ogden, David, Deputy Attorney General. *Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana*, October 19, 2009, available at <http://www.justice.gov/opa/documents/medical-marijuana.pdf>.

⁹ Eddy, Mark. *Medical Marijuana: Review and Analysis of Federal and State Policies*. 17-23 (March 31, 2009), available at <http://www.fas.org/sgp/crs/misc/RL33211.pdf>.

marijuana activity was medically related and legal under state law have been introduced in recent Congresses and are likely to be reintroduced in the 111th Congress. Past proposals to move marijuana from Schedule I to Schedule II of the CSA might also resurface in the current Congress.

The Obama Administration's Attorney General has signaled an end to federal raids by the Drug Enforcement Administration of medical marijuana dispensaries that are operating in accordance with state laws, in fulfillment of a pledge to end such actions that was made by candidate Obama during the presidential campaign.

Thirteen [now fourteen] states, mostly in the West, have enacted laws allowing the use of marijuana for medical purposes, and many thousands of patients are seeking relief from a variety of serious illnesses by smoking marijuana or using other herbal cannabis preparations. Meanwhile, the federal Drug Enforcement Administration refuses to recognize these state laws and continues to investigate and arrest, under federal statute, medical marijuana providers and users in those states and elsewhere.

Claims and counterclaims about medical marijuana—much debated by journalists and academics, policymakers at all levels of government, and interested citizens—include the following: Marijuana is harmful and has no medical value ; marijuana effectively treats the symptoms of certain diseases; smoking is an improper route of drug administration; marijuana should be rescheduled to permit medical use; state medical marijuana laws send the wrong message and lead to increased illicit drug use; the medical marijuana movement undermines the war on drugs; patients should not be arrested for using medical marijuana; the federal government should allow the states to experiment and should not interfere with state medical marijuana programs; medical marijuana laws harm the federal drug approval process; the medical cannabis movement is a cynical ploy to legalize marijuana and other drugs. With strong opinions being expressed on all sides of this complex issue, the debate over medical marijuana does not appear to be approaching resolution.

II. Medical Cannabis Working Group Formation

Governor Lingle's vetoes and failure to convene the task force contravened the Legislature's intent in passing Act 29 and ignored both the shift in federal policy and changes to other states' laws. Some of the newer state laws, for example, had provisions for state-sanctioned cannabis distribution centers, reciprocity among medical cannabis states, increased caregiver to patient ratios and other program improvements requested by patients in Hawai'i.

Consequently, many medical cannabis patients, physicians and legislators supported setting up a mechanism for re-examining the program and recommending improvements. Senator Espero, as Chair of the Senate Committee on Public Safety and Military Affairs and primary sponsor of the task force bill, took the lead.

Senator Espero proposed that MCWG be convened to do the work of the task force as described in Act 29. The original task force called for representatives from several state departments including Public Safety, Health, Transportation, the Attorney General, and the

Board of Agriculture. However, MCWG, as an unofficial state entity, could not compel the participation of the state agencies that had been named in the original legislation.

Senator Espero invited representatives from non-governmental groups named in Act 29 to participate and asked Pamela Lichty, President of the Drug Policy Forum of Hawai`i, and Laurie Temple, Staff Attorney of the American Civil Liberties Union of Hawai`i, to co-chair MCWG. Most of the resulting members represented organizations named in the initial legislation, although additional members or subcommittee volunteers were added later.

One of the tasks of Act 29 was completed and submitted before the veto took place and MCWG was convened. The Legislative Reference Bureau, pursuant to their assignment in Act 29, completed a report on *“The policies and procedures for access, distribution, security, and other relevant issues related to the medical use of cannabis for all the states that currently have a medical cannabis program.”*¹⁰

A. MCWG Mandate

Using language echoing that in Act 29, MCWG was asked to:

1. Examine current state statutes, state administrative rules, and all county policies and procedures relating to the medical marijuana program;
2. Examine all issues and obstacles that qualifying patients have encountered with the medical marijuana program;
3. Examine all issues and obstacles that state and county law enforcement agencies have encountered with the medical marijuana program;
4. Compare and contrast Hawaii’s medical marijuana program with all other states medical marijuana programs; and
5. Address other issues and perform any other function necessary as the taskforce deems appropriate relating to the medical marijuana program.

B. MCWG Members

Senator Espero – Convener, Senate Committee on Public Safety and Military Affairs Chair
Pamela Lichty, M.P.H. – MCWG Co-Chair, Drug Policy Forum of Hawai`i President
Laurie Temple – MCWG Co-Chair, American Civil Liberties Union of Hawai`i Attorney
R.C. Anderson – Director, Honolulu Americans for Safe Access
David J. Barton, M.D. – Pain and Palliative Medicine Specialist
Anne E. Biedel, M.D. – Healthcare Provider
Michael A. Glenn, Esq. – Caregiver
Gary L. Greenly - D.O. – Healthcare Provider
Marvin Merritt – Patient
Joseph Rattner, O.D., C.S.A.C. – West Oahu Hope for a Cure Founder and President
Charles Webb, M.D. – Healthcare Provider

¹⁰ See Appendix G for the report, *“Access, Distribution, and Security Components of State Medical Marijuana Programs,”* by Lance Ching, Research Attorney, Legislative Reference Bureau.

C. Volunteers and Subcommittee Members

MCWG decided at the first meeting that subcommittees should be formed to research and report on the various issues and report back to the MCWG. Each subcommittee consisted of at least one member of MCWG plus community member volunteers. Each committee's charge is described below along with the participants' names. There was inevitably some overlap in both the charge and the findings and recommendations of each group.

1. Patient and Caregiver Issues Subcommittee

Mandate: To examine all issues and obstacles that qualifying patients and caregivers have encountered with the medical marijuana program in Hawai'i.

Members:

Joseph Rattner – Subcommittee Co-Chair and MCWG member
Marvin Merritt – Subcommittee Co-Chair and MCWG member
Doran Chavez – volunteer
Teri Heede – volunteer
Mark Nelson – volunteer
Lila Rattner – volunteer

2. Access and Distribution Issues Subcommittee

Mandate: To examine all issues and obstacles that qualifying patients and caregivers encounter in acquiring or growing medical cannabis in Hawai'i.

Members:

Joseph Rattner – Subcommittee Co-Chair and MCWG member
Marvin Merritt – Subcommittee Co-Chair and MCWG member
Doran Chavez – volunteer
Teri Heede – volunteer

3. Transportation and Security Issues Subcommittee

Mandate: To examine all issues and obstacles that qualifying patients and caregivers encounter when attempting to transport their medical cannabis in Hawai'i.

Members:

Michael Glenn – MCWG member
Matt Rifkin – volunteer

4. Physician Issues Subcommittee

Mandate: To examine all issues and obstacles faced by physicians who may wish to participate in the medical cannabis program.

Members:

David Barton, MD – MCWG member
Anne E. Beidel, MD – MCWG member

Gary L. Greenly, DO – MCWG member
Charlie Webb, MD – MCWG member
Sandy Webb, RN – MCWG member
Jeanne Ohta – volunteer

5. Public Safety Issues Subcommittee

Mandate: To examine all issues surrounding law enforcement and the medical cannabis program

Members:

Pam Lichty – MCWG Co-Chair
Laurie Temple – MCWG Co-Chair
Robert Bacher – volunteer
Don Eads – volunteer

D. MCWG Process

MCWG met as a whole six times between October and December of 2009, including during a community forum billed as a “Talk Story Session.”¹¹ In between the formal meetings held at the state capitol, the subcommittees met and/or conducted their deliberations via phone and email.

MCWG developed and disseminated a Medical Cannabis Patient Questionnaire to which more than 100 responses were received via fax and mail.¹² The responses were compiled by Marlene Uesugi, Office Manager for Senator Espero.

Each subcommittee submitted the reports below, which were then compiled and edited by co-chairs, Pam Lichty and Laurie Temple.

III. Subcommittee Reports

A. Patient and Caregiver Issues

Mandate: To examine all issues and obstacles that qualifying patients and caregivers have encountered with the medical marijuana program in Hawai`i

Members:

Marvin (Mark) Merritt – Subcommittee Chair
Lila Rattner – volunteer
Teri Heede – volunteer

1. Introduction

In April 2000, Hawai`i became the first state to legislatively permit the medicinal use of cannabis. This subcommittee’s purpose is to identify patient and caregiver issues

¹¹ See Appendix H for the full report of the Talk Story session.

¹² See Appendix I for the text of the MCWG Questionnaire and Appendix J for the result summary.

encountered while attempting to comply with Act 228, SLH 2000, Medical Use of Marijuana as specified in chapter 329, part IX, Hawai‘i Revised Statutes.

Despite the Legislature’s passage of Act 228, healthcare professionals are still not trained on the use of cannabis; patients who might benefit from its use are not aware of it; and patients who do use it risk legal consequences. Patients face a myriad of problems in attempting to safely and legally access medical cannabis.

For instance, patients who are disabled and injured veterans are being denied access to cannabis as a medication and if they do follow a cannabis protocol, fear denial of other veterans’ services if they test positive for use.¹³ Veterans returning home from war deserve the highest level of healthcare that this country can provide but are denied it.

Homeless patients have other unique issues that encompass the full breadth of patient and caregiver problems. Further, they have no insurance, no home and already are at great personal physical risk before trying to obtain or store cannabis. Growing is not an option for homeless individuals.

Patients and caregivers are highly motivated to comply with the current law, but encounter almost insurmountable obstacles when obtaining a safe and adequate supply. The risk of arrest and fear of prosecution causes many patients and caregivers unnecessary stress and the associated anxiety exacerbates pre-existing health conditions.

2. Findings

The following findings are a compilation of information obtained from patients, caregivers and healthcare professionals who testified before MCWG, submitted questionnaires and were personally interviewed regarding problems they encounter in Hawai‘i while trying to legally acquire an adequate supply of medicinal cannabis.

- a. Patients do not have access to a safe and legal supply of medicine.

Patients and/or caregivers are often forced to find black market sources to obtain medication where the risk of violence and robbery always exists. One patient in Hawai‘i reported that she was “on the streets” trying to acquire medicine when she was detained by police and accused of prostitution. Other patients report being “ripped off,” accosted, or placed at great physical risk and receiving low quality cannabis, which is unacceptable or ineffective as medication, from black market sources. All patients agree that using a black market source for medication is the least acceptable methodology for acquiring medication and leads to further anxiety over the fear that money spent on the black market could be redirected for a more nefarious purpose.

- b. Patients do not have and/or cannot find a primary caregiver.

Patients unable to grow their own supply receive no guidance on sources for caregivers from the NED or their doctors.

¹³ See Appendix K for more information on this issue from the Department of Veterans Affairs.

- c. Patients do not have a mechanism to exchange information with other patients.

Patients want to interface with other patients, exchange information and experiences so that they can benefit from their knowledge. Many are already isolated by illness and feel quarantined by law enforcement and state regulations.

- d. Patients are currently not able to obtain an adequate supply of medicine under the current constraints of the act with the limitations of one caregiver.

The current growing and dispensing guidelines are not working and patients do not want a “black market” solution to this issue. Patients need more caregivers and/or caregivers need to be able to provide for more patients.

- e. Patients’ physical limitations and/or illness prevent or inhibit them from growing medical cannabis themselves.

It is next to impossible for most patients and caregivers to acquire the expertise, time and intense cultivation to produce an adequate supply of medical cannabis. Further, access to outdoor or indoor gardens is difficult to impossible for those patients who are permanently confined to a wheelchair.

- f. Patients need a safe, adequate, high quality and diverse source of medication.

Patients consistently reported that they require specific strains in specific amounts to target specific ailments and symptoms. Patients in Hawai‘i have no mechanism to obtain the variety of cannabis needed to address a full range of patient medical issues. Access to a variety of seeds and propagated plants (commonly referred to as clones) is very difficult or impossible under the current regulations. Patients requested that the state sanction clinical trials to identify which varieties of medicinal cannabis work best for their specific ailments so that they are able to receive the best treatment.

- g. Many patients are on limited incomes and health insurance doesn’t cover the cost of medical cannabis.

Patients cited cost concerns regardless of their current means of access. Patients who purchase off the black market face high prices and unpredictable price fluctuations. Home cultivation requires expensive equipment and additional utility costs.

- h. Patients do not know which physicians they can contact because there is not a list of participating physicians in Hawai‘i who routinely conduct certification exams.

NED provides little to no information to patients on certifying physicians. Patients reported delays in certifications and renewals because the physicians they do find are from the mainland or a neighbor island and may not hold clinics regularly.

- i. Patients and physicians need to access registration forms on a website.

Other states (*e.g.*, Oregon) have patient registration forms available on websites, but in Hawai‘i, NED will only fax them to physicians upon request.¹⁴ Patients report that they need to access the forms so that they can take them to a physician’s office when they discuss certification exams and procedures. It is common for patients in Hawai‘i to discuss the medicinal use of cannabis with healthcare providers who do not have information on medical cannabis use and regulations. The majority of patients reported that *they* typically provide information to the physician on how to navigate Hawaii’s medical marijuana laws and the forms that have to be filed because many physicians are unaware of how the program works.

- j. Patients report that they pay yearly fees to certification clinics.

These costs vary greatly amongst certification professionals and none of the fees are covered by insurance.

- k. Patients require presumptive eligibility, which would insure they do not have to wait to obtain medicine while the paperwork for a card is processed.

No certified patient should be denied medication while they wait for their certification card, but sometimes patients have to wait for a certification group to come from the mainland, conduct a clinic, certify patients and then file the necessary paperwork and then wait longer for NED to send their certification. There have been reports by patients in Hawai‘i that they have experienced delays as great as six months from the time of their certification exam to the day they receive their cards.

- l. Patient confidentiality and security is at risk because their address is on the certification card.

Patients do not want to have their address on the certification card because it is then made clear where the medical cannabis is being grown. Patients feel that this creates an opportunity for theft if someone sees the card or if it is stolen or lost.

- m. Patient confidentiality regarding information and records has been compromised by NED.

Hawai‘i rules specify that the data files maintained by NED will include all information collected on the registration forms and any other information that they might have collected from the patient. The rules specifically state that “*this information shall be confidential and not subject to public disclosure.*” However, NED emailed the entire patient database to a Hilo newspaper in 2008.

¹⁴ See Appendix L for NED Patient Guidelines.

- n. Patients are not compensated by law enforcement when their medicine is wrongly seized.

Law enforcement officers who wrongfully seize a patient's medical cannabis should be held liable to the patient for the black market value of the patient's seized medication.

- o. Patients who do not own their own homes cannot grow their own cannabis.

Patients in rental units and public housing face eviction for growing or using medical cannabis and homeowners risk asset seizures and prosecution if they are found to be growing medical cannabis. Adult homes, nursing homes and hospice facilities reportedly also have policies preventing patients from possessing, using or growing medical cannabis.

- p. Healthcare providers are intimidated and misinformed about certification exams for patients and are not allowed to write prescriptions.

Physicians are not given any information by NED and are forbidden from writing prescriptions by NED and, as such, lack the ability to make informed decisions about their patients' treatment.

- q. Family members/caregivers are concerned about second hand exposure because they may test positive on their employment related drug tests.

Current workplace laws make life for medical cannabis patients, caregivers and family members particularly difficult because they rarely take medical use or secondhand exposure into account. For instance, urinalysis for cannabis is not able to determine whether a person used medical cannabis 10 minutes or 30 days before the test, much less if it the test was positive because of second hand exposure. Patients, caregivers and family members report that they do not know what to do if they do test positive.

- r. Patients risk losing custody of their children for using or growing medical cannabis.

Many patients fear that their use of medical cannabis will be used against them in child custody cases. Patients need guidance on how to participate in the program and not lose custody of their children and other legal rights.

- s. Patients have a hard time keeping track of their certification's annual expiration date.

NED does not send renewal applications to medical cannabis patients prior to their certification expiration, despite the fact that most other state programs in Hawai'i do so. For example, all Hawai'i registered vehicles must be renewed on an annual basis in the county where the vehicle is registered and being driven. Renewal application forms are mailed to the registered owner at the address of record approximately 45 days before the vehicle's expiration date.

- t. Patients have only five working days with which to notify NED of their change of address which can be very difficult or impossible to comply with.

Patients should be allowed more time to notify NED of a change in address before losing their program certification (similar to what is required for cars). For example, if you have shipped your vehicle to Hawai‘i from the mainland or anywhere in the world, the State of Hawai‘i requires that you register the vehicle within 30 days of its arrival.

- u. NED changes the registration form from time to time without notifying patients (*e.g.*, requiring more information or the signature of a “primary care physician”).

These arbitrary changes create confusion for patients and healthcare providers trying to negotiate which policies to follow.

- v. Patients are not given timely and accurate information about the program.

Patients reported that they perceived NED – as a law enforcement agency – as unwilling to provide patients with program information, thus leading to further impediments to patient compliance with the law.

- w. Patients and healthcare providers have been given enormous amounts of misinformation represented as facts.

For example, some patients reported they have been told by various sources that cannabis can make them schizophrenic. There is general agreement that heavy cannabis use can precipitate schizophrenic episodes, but there is no evidence that it can cause the underlying psychotic disorder. It is a fact that if a patient has a mental health problem, taking a drug – any drug – excessively is going to make the patient’s problems worse but many patients are not told this.

Many patients are told by various sources to worry about addiction, although there are recent studies indicating that cannabis is nowhere near as addictive as nicotine or alcohol and that dependency on cannabis can be more accurately compared to caffeine dependency. Patients also reported that when they use medical cannabis they experienced the additional benefit of being able to mix it with other prescriptions without harmful side effects (and that, in fact, the cannabis helped to counteract the side effects of prescription drugs).

- x. The regulation does not distinguish or correlate what is the correct “adequate supply” required for each affliction based on the variety of cannabis species that will provide the optimum effect for a specific affliction.

Further, there is no discussion in the regulation regarding plant gender. Only female plants produce the required medicine and it is very difficult to determine the difference between a male and female plant during the foliage production stage of growth (vegetative state). NED representatives do not have the educational background or knowledge in horticulture to

distinguish a male from a female plant. Finally, the regulation does not discuss short term and long term plant quantities. For those patients or caregivers that grow plants from seed or vegetative cuttings, additional plants will be required. Thus there will be a quantity of female plants required to produce the medical cannabis and a quantity of female and male plants to produce seed or vegetative cuttings to continue the supply of plants.

- y. Patients and caregivers regarding adequate access to resources and information regarding growing cannabis in general along with the peculiarities between different species/varieties.

Further, there has been no discussion on the correct process/tasks/techniques required during pre-harvest, harvest and post-harvest stages of plant care. To receive the optimum affect from the medical cannabis, correct watering time frames and quantities, fertilization schedules and formulas (Nitrogen-Phosphorus-Potassium ratios) for both foliage and floral production, pruning techniques and time frames, soil or water type/pH requirement, planting requirements, light time frames and color spectrum range requirements, for both foliage and floral production, mature plant maximum root mass development for each cannabis variety for container grown plants, disease and insect problems associated with cannabis varieties, ventilation requirements for disease and insect control, mature height and spread of each variety and proper curing/drying procedures will be required for both patients and caregivers requesting to grow their own plants.

Similar to how plant nurseries provide this information for the various types of vegetables, annuals, shrubs, ground cover and trees sold to the public, medical cannabis patients should receive the same assistance and information.

3. Interviews

Patients, caregivers, healthcare professionals, family members and interested parties from the public were interviewed in person, by phone, via email and fax. People also provided feedback on the current complex issues surrounding the program at a public forum hosted by MCWG. Included here is a sampling of the information collected from patient interviews:

- a. Patient A (Personal Interview)

“The cost of cannabis prohibits me from having an adequate supply. Insurance doesn’t cover any of my medical costs associated with cannabis and I just can’t afford to pay the black market price.”

Patient A cannot grow because Patient lives in a rental unit. Sometimes Patient must go without medicine because of the cost and, to add insult to injury, Patient doesn’t always get the strain or quality of medicine Patient needs once Patient can acquire cannabis. Patient A doesn’t know how to grow even if Patient was well enough; Patient does not have a primary caregiver and does not know how Patient would get one.

b. Patient's Caregiver B (Personal Interview)

"How are renters supposed to grow?"

Caregiver B stated Caregiver cannot grow in Caregiver's rental unit so Caregiver is forced to buy off the black market and Caregiver's patient's cannabis requirements far exceed Caregiver's and patient's ability to pay. Caregiver would like to participate in a cooperative grow operation where Caregiver could maintain Caregiver's own plants. Caregiver would fully support a dispensary for patients.

c. Patient's Relative C (Personal Interview)

"My brother needs a caregiver but I can't possibly do it because of my job."

Patient's Relative C stated that patient lives in an apartment and cannot grow medical cannabis. Relative would like to help patient but is afraid that employment would be in jeopardy. Relative doesn't know how to find a caregiver for patient and knows absolutely nothing about the regulations surrounding medical cannabis.

d. Patient D (Personal Interview)

"I need safe access to medicine."

Patient D had a list of issues and concerns starting with discrimination in housing and on the job. Patient has a hard time getting seeds and plants to grow, needs more education on strains and dosages, wants a dispensary or coop available to patients, and wants to increase the number of allowable plants and remove the mature/immature restrictions. Patient would like to see the patient to caregiver ratio increased and is concerned about the lack of available caregivers. Patient was also concerned that if Patient does grow and has cannabis in excess of the regulation, can Patient store it for later use? Patient also does not like to acquire cannabis on the black market because it may not be safe and is very expensive.

e. Caregiver E (E-mail)

"Knowing how much medical cannabis is required for the patient that I care for; the amount of plants allowed for by the current regulation does not come close to amount required by my patient."

Caregiver E has concerns about access to quality cuttings (clones) of the cannabis species that alleviates the patient's affliction. The use of seed for new plants does not guarantee it will be of the same cannabis species nor does it guarantee it will be a female plant, thus the legal amount of plants currently could all be males if seeds are used as the primary method for growing plants. The current amount of plants allowed by the regulation that are in flower cannot sustain a patient to the next harvest from the plants in a vegetative growing cycle. Further, if plants are grown outdoors, season also adds a concern to a consistent supply of medical cannabis. During the winter season there will be less growth, thus less medical cannabis for the patient. If growing indoors, the cost for utilities, such as electrical and water, for fertilizers, for soil median and for light fixtures, containers and fans pushes the cost up which can be difficult for patients on limited income.

Caregiver E supports growing coops that would be able to supply healthy plants of the right species/variety for the affliction in question and either increasing the amount of plants that can be grown by a patient or changing the regulation to a square foot area, such as a 100 square feet, where any amount of plants can be grown within this area.

f. Patient F (Personal Interview)

“I began having headaches from the prescribed medication that are called “suicide headaches” because they are so disabling you just want to kill yourself and be put you out of your misery.”

Patient F has MS and other health problems and has been prescribed a cornucopia of pharmaceuticals to alleviate symptoms which have caused permanent damage to Patient’s liver, stomach and bowels. Associated with MS are muscle spasms, neurological problems and pain that have only been alleviated by medicinal cannabis. Patient F’s disability prevents Patient from growing a garden and managing life on an income of disability pension/Social Security makes black market cannabis unaffordable. Patient F supports dispensaries and patient growing coops and demands that NED be removed from oversight of the program.

g. Patient/Healthcare Professional G (Telephone)

“I am doing a presentation for other Healthcare workers.”

Patient/Healthcare Professional G is trying to educate him and others on issues surrounding medical cannabis. Patient received information that his certification was in jeopardy due to a physician licensing problem in August of 2009 so Patient went to another physician in October of 2009. Patient still has not received Patient’s certification card. NED is not sending Patient information or returning Patient’s calls. He is very supportive of AMA’s recommendation to remove cannabis as a Schedule 1 drug.

h. Patient H (Phone)

“There is a unique element of cruelty when patients can grow.”

Patient H cited safe access to medication as a paramount issue. The patient had to wait 8–10 weeks for the card, then another 10 weeks to grow, harvest and dry, so it was 20 weeks before the patient had medication. The harvest exceeded the amount he could legally keep, so he did not know how to legally dispose of the excess. The patient feels that law enforcement is inhumane and sick and that they are creating an environment where black market money leaves the island.

B. Access and Distribution Issues

Mandate: To examine all issues and obstacles that qualifying patients and caregivers encounter in acquiring or growing medical Cannabis in Hawai'i.

Members:

Joseph Rattner (Subcommittee Co-Chair) – MCWG member
Marvin (Mark) Merrit (Subcommittee Co-Chair) – MCWG member
Doran Chavez – volunteer
Teri Heede – volunteer

1. Introduction

In April 2000, Hawai'i became the first state to legislatively permit the medicinal use of cannabis. The purpose of this subcommittee is to examine all issues and obstacles that qualifying patients and caregivers encounter when attempting to access and/or distribute therapeutic cannabis.¹⁵

There are two legal models operating under the current legislation in Hawai'i:

1. The Patient Model is simply patients growing their own medicine for personal use.
2. The Caregiver Model is a designated person growing cannabis for a patient who is unable to grow it themselves.

2. Findings

Focusing on the need to redefine our approach to drug law enforcement and working in partnership with the community, the following information and recommendations are submitted.

a. Patients Need Safe Access to Medical Cannabis

Patients require safe, consistent doses of medication to obtain optimal benefits. It is possible to scientifically assess the safety and potency of cannabis prior to ingestion and should be authorized and utilized for patient safety and quality assurance.

New information that draws correlations between the main psychoactive ingredient THC and other non-psychoactive cannabinoids (CBD) and cannabitol (CBN) indicate that many patients can achieve medicinal benefit with a non-psychoactive effect. Accurate testing and labeling for patients is essential.

A well established and reputable California dispensary reported:

"It's expensive to test every single thing that comes through the door -- that's the price you pay with a decentralized supply system. . . . But that's what you've got. You've got five pounds coming from here and two from there and

¹⁵ Washington State did a similar and very thorough examination of many of the issues this subcommittee studied. Their report can be found at <http://www.doh.wa.gov/hsqa/medical-marijuana/docs/PatientAccess.pdf>.

*one individual. I mean, a dog walks in the grow room, and wags its tail -- anything can be coming off that dog's tail. It's gross. Fertilizers with E. Coli. Compost teas that they don't make right, anaerobic tea that has elevated levels of E. Coli and salmonella. It has to come. There's no way that this is sustainable. All it takes is one story of immune-compromised people dying from aspergillus infection. The myth that Cannabis hasn't killed a single person in 3,000 years is allowed to go on. Well, it's not Cannabis that kills people, it's all the shit that's in it."*¹⁶

While arrest and jail may remain a constant worry for the aforementioned dispensary and the laboratory's owners, the quality assurance and dosage information is assured for the patients. This is accomplished with gas chromatography, flame ionization, and mass spectrometry tests on cannabis.

b. Distribution Models

Our subcommittee looked at any existing cannabis distribution model that could provide a safe, affordable system while still being respectful not only of the patients but also of the community as a whole. The optimal functional distribution system in Hawai'i will utilize the local market forces to create networks of growers who supply local distributors with a steady supply of safe, quality cannabis. This would allow the sales of cannabis to be taxed in such a manner that the state of Hawai'i realizes revenue from any production.

The term cooperative comes from the concept of farmers joined together to market and share their products (in this case cannabis) as a group of buyers and sellers versus a collective which grows together, but does not market their product together. A collective would be defined as a group of patients helping each other grow cannabis for personal use.

The Cooperative/Collective Model seeks to combine the efforts of patients and caregivers, as the two work together to educate the public and grow Cannabis. Each individual involved is expected to give what he or she can to the endeavor. In return, the cooperative/collective offers its members safe access to medical Cannabis, often at no cost. Cannabis seeds, cuttings, plants and other information about home cultivation would be shared.

The Dispensary Model (Pharmacy Model¹⁷) is perhaps the most simple, basic mechanism through which patients receive medical cannabis. Each dispensary maintains its own membership of legally qualified patients, and those members are allowed access to safe and affordable Cannabis medicines. Commercial suppliers would be required and would label their products with consumer information concerning weight, THC/CBD/CBN content, recommended dosage and approved health warnings.

A Dispensary/Cooperative with Patient Services (Social Club Model) is a more comprehensive model. This dispensary does not simply provide its members the opportunity to secure safe, medical-grade cannabis, but also offers other services to meet the needs of the patients' general well-being. In this way, the dispensary becomes its patient's primary

¹⁶ Downs David, *The Manhattan Project of Marijuana*, Mar. 4, 2009.

¹⁷ The NORML Conference Discussion Panel, *Cannabis Dispensaries and Their Carrying Capacities*, April 21, 2006.

caregiver, as well as a provider of medicine. At these facilities, health professionals including nurses, doctors, and alternative medicine therapists provide consultations and other services. Attorneys provide legal training to educate patients and caregivers as to their constitutional protections. Grow workshops are another common service provided, along with peer counseling groups, classes, special events, and hospice style care. A range of products from rolled cigarettes to cannabis edibles may be available, together with smoking implements designed to reduce the level of harm associated with smoking cannabis products (e.g., bongs or vaporizers) and other “take away” products. Cannabis seeds, cuttings, plants and other information about home cultivation could also be available. Commercial suppliers would be required to label their products with consumer information concerning weight, THC content, recommended dosage and approved health warnings.

3. Recommendations

a. Establish a Distribution System

There is no evidence that a self-sustaining group of medical cannabis patients can successfully cultivate cannabis without a lot of strong healthy people to do a lot of the work. For example, if you use a dirt mix for quality reasons, it’s a lot of work, and the problem with sick people trying to help other sick people is that good intentions outweigh the possibility of actualization when growing is labor intensive. Additionally, this type of activity in the community is sometimes met with the highest possible resistance. One example of problems in a neighborhood occurred in Seattle when the activity generated by regular cannabis plant maintenance at a residence prompted a “Cease and Desist” because of community complaints. We must establish a “good neighbor policy” with any production and distribution model.

Any functional Hawai‘i production and distribution model would capitalize on an existing network of local growers who would supply local distributors with a sustainable, organic supply of quality cannabis.

We recommend that the State approve and adopt a working model that would begin with the establishment of clinical trials that would facilitate in the further refinement of an effective and efficient production and distribution model. The authorization and establishment of a Hawai‘i based laboratory to test medicinal cannabis under the proper protocols is essential to ensuring safe medication and should be included in the model.

One of the concerns of public officials is that dispensaries make possible or even encourage the resale of cannabis on the street. However, 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 the ease for law enforcement of monitoring openly operating facilities, dispensaries universally have strict rules about how members are to behave in and around the dispensary. Many have “good neighbor” trainings for their members that emphasize sensitivity to the concerns of neighbors, and all absolutely prohibit the resale of cannabis to anyone. Anyone violating that prohibition is typically banned from any further contact with the dispensary.

Dispensary operators and their patient members tend to be more safety conscious than the general public, resulting in great vigilance and better preemptive measures. The reduction in crime in areas with dispensaries has been reported anecdotally by law enforcement in several

communities. 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.¹⁸

b. Transfer Oversight of the Medical Cannabis Program to the State Department of Health

Hawai‘i medical cannabis regulations are best handled through the Hawai‘i State Department of Health (“DOH”), not NED, to ensure the protection of qualified patients, caregivers, and dispensaries. General regulatory oversight duties – including permitting, record maintenance and related protocols - should be the responsibility of DOH. Given the statutory mission and responsibilities of DOH, it is the natural choice and best-suited agency to address the regulation of any medical cannabis dispensing model. Law enforcement agencies are ill-suited for handling such matters, having little or no expertise in horticultural, health and medical affairs.

c. Establish Reciprocity With Other States

We recommend that once a distribution program is established in Hawai‘i , we participate in reciprocity with other states that have a medicinal cannabis program.

d. Implement Electronic Management Solutions

Many legitimate collectives, cooperatives, dispensaries, and caregivers utilize HIPAA compliant patient management software to successfully maintain patient’s privacy and medical records. In addition, point of sale systems integrate with these records so each caregiver can discuss, with the patient, past experience with particular strains and medicines and make recommendations on this, confidential information in order to assist the patient with finding the correct strain for their unique ailment. This is extremely critical for creating legitimacy for safe access to medical cannabis. These software based solutions are used to successfully maintain patient records, operate, manage, and measure all critical metrics for the dispensary.

Hawai‘i could benefit immediately from this HIPAA compliant software. Using this HIPAA compliant solution, receiving the doctor's recommendation and providing a State issued certification would be prompt, reliable and extremely confidential. For example, an organization named Agoraware, Inc. currently provides these solutions for dispensaries and caregivers in Colorado and could assist Hawai‘i in developing a similar program.

¹⁸ Americans for Safe Access, *Medical Cannabis and Dispensing Collectives and Local Regulation*, 2006.

C. Transportation and Security Issues

Mandate: To examine all issues and obstacles that qualifying patients and caregivers encounter when attempting to transport their medical cannabis and/or paraphernalia in Hawai‘i.

Members:

Michael Glenn – MCWG member

Matt Rifkin (patient) – volunteer

1. Introduction

Hawai‘i law currently allows for the medical use of cannabis by registered patients and caregivers. Medical use of cannabis, under Hawai‘i law, includes the acquisition, possession, cultivation, use, distribution, or transportation of marijuana or paraphernalia relating to the administration of marijuana to alleviate the symptoms or effects of a qualifying patient’s debilitating medical condition.¹⁹ Any discussion of “transportation,” by definition, must literally include a discussion of “possession after acquisition” or “travel for acquisition” of cannabis.

The unique status of Hawai‘i as an island state, with travel between islands and beyond essentially only by air, results in many of Hawaii’s state-registered and compliant medical cannabis users and caregivers passing through security checkpoints at airports. While the actual passenger screening is conducted by the federal Transportation Security Administration (“TSA”), actual security is handled by local sheriff’s deputies or sometimes by contracted security such as *Securitas*.²⁰ Many Hawai‘i medical cannabis patients and their caregivers have experienced confiscated/stolen cannabis, or have not traveled or traveled without their cannabis out of fear. Additionally, some Hawai‘i medical cannabis patients and caregivers have experienced problems at various non-airport security checkpoints and X-ray screenings when those checkpoint personnel did not respect the patients’ or caregivers’ rights to possess cannabis.

This report will address the transportation of cannabis as allowed by current statute and suggest changes that might help eliminate the obstacles (both real and perceived) that Hawaii’s citizens encounter while transporting their cannabis. This report will not address the actual “use” of cannabis, nor its “cultivation.” The other listed term in the statutory definition of medical use of marijuana – “distribution”²¹ - is currently explicitly defined for the purposes of medical use, as limited to the transfer of marijuana and paraphernalia from the primary caregiver to the qualifying patient.

2. Findings

¹⁹ See Appendix A.

²⁰ See Appendix M for information on the Department of Public Safety’s Sheriff’s Division and Appendix N for NED.

²¹ The authors note that this hyper-definition of “distribution” is logically inconsistent with all of the other words listed in the definition of medical use; renders “acquisition” impossible; fails to explain where or how the caregiver is to obtain the caregiver’s cannabis so that the caregiver may transfer it to the patient; and utterly fails to acknowledge that some patients do not even have a caregiver.

No written state or county policy is currently in place which specifically concerns inter-island transportation of medical cannabis. This results in improper, haphazard, and inconsistent results for Hawaii's medical cannabis air travelers.

Some patients have reported that their cannabis has been seized and that they have been threatened with arrest. Some caregivers have reported that they would refuse to fly with a live plant, thus seriously limiting the transportation of cannabis plants in living and growing form. Some patients have been threatened with arrest while some have had no problem flying with their cannabis. In a preliminary analysis, over half of patients and caregivers (35 of 62 respondents to MCWG questionnaires) indicated that they indeed encountered problems traveling with their medicine. Many of those commented that they have left their medical cannabis home, out of fear, rather than travel with it.

According to the Department of Public Safety Report to the 2009 Legislature / Narcotics Enforcement Division FY2008 Annual Report:

During FY2008, NED Investigators responded to 891 cases, 573 criminal and 318 regulatory, compared to FY2007's 827 cases, 476 criminal and 351 regulatory. Increased security at the airport since the September 11, 2001, terrorist incident have resulted in an increase in the number of controlled substance being detected at airport checkpoints and through the mail. During Fiscal Year 2008 NED Investigators investigated 115 controlled substances and drug paraphernalia cases referred by the Airport Sheriff Detail at security checkpoints, 8 cases referrals by the Bureau of Immigration and Customs Enforcement (BICE)/ US Postal Service relating to illegal importation or smuggling of pharmaceutical and illicit controlled substances into Hawai'i and 52 by NED's HIDTA Airport / DEA task force Investigators for controlled substances or regulated chemicals being smuggled into Hawai'i.

Of note in this NED report is the significant increase in the amount of cannabis seized at the airports of Hawai'i from calendar year 2007 compared to 2008 (only through August). The NED seized 9,913 grams (354 ounces) of cannabis in 2007 yet seized 23,256 grams (830 ounces) of cannabis the first eight months of 2008.

The report makes no mention of any alleged or actual medical cannabis being seized, nor are any medical cannabis transportation issues raised in this report.

For those patients/caregivers who have had their cannabis seized or who fear having their cannabis seized at security checkpoints, current law provides for what is to become of the cannabis. HRS 329-127 provides for the protection of marijuana and other seized property by requiring that marijuana, paraphernalia, or other property seized from a qualifying patient or primary caregiver in connection with a claimed medical use of marijuana shall be returned immediately upon the determination by a court that the qualifying patient or primary caregiver is entitled to the protections of this part, as evidenced by a decision not to prosecute, dismissal of charges, or an acquittal; provided that law enforcement agencies seizing live plants as evidence shall not be responsible for the care and maintenance of such plants.

Patients also report being arrested while transporting their medicine in their vehicles. Police often do not know about the medical cannabis law; have never seen a certification card and

prefer to arrest patients and “let the court sort things out.” This causes great emotional harm to patients and is time consuming and costly. The police need to be educated on the law and have specific protocols and procedures to follow when they encounter a patient or caregiver transporting cannabis.

3. Current Law

Per their website, www.tsa.gov, TSA prohibits certain items past the security checkpoint at all U.S. airports. While this list includes items that are a danger to the plane/crew/passengers, cannabis is not on the list of prohibited items. There is a list of “special items” which does include “medications.” This list states very clearly that you may bring all prescription and over-the-counter medications (liquids, gels, and aerosols) including petroleum jelly, eye drops, and saline solution for medical purposes onboard the plane.

TSA's September 25, 2006 *Memo to Passengers with Disabilities and Medical Conditions Using Air Transportation* notes that it is recommended (not required) that passengers bring along any supporting documentation (e.g. ID cards, letter from doctor, etc.) regarding their medication needs. It is recommended, not required, that the label on prescription medications match the passengers boarding pass. If the name on prescription medication label does not match the name of the passenger, the passenger should expect to explain why to the security officers. To ensure a smooth screening process, passengers are encouraged to limit quantities to what is needed for the duration of the flight.

Furthermore, the Code of Federal Regulations General Operating and Flight Rules Section 91.19, entitled *Carriage of narcotic drugs, marihuana [sic], and depressant or stimulant drugs or substances*, states that while no person may operate a civil aircraft within the United States with knowledge that narcotic drugs, marihuana, and depressant or stimulant drugs or substances as defined in Federal or State statutes are carried in the aircraft, the restriction does not apply to any carriage of narcotic drugs, marihuana, and depressant or stimulant drugs or substances authorized by or under any Federal or State statute or by any Federal or State agency.

Because TSA screeners may not lawfully seize any cannabis from Hawaii’s patients and caregivers, it is up to local law enforcement to deal with any alleged controlled substance violations at these checkpoints.

4. Recommendations

a. Establish Written Policies and Procedures for Law Enforcement and Security Personnel

One proposal that would not involve changing or modifying any law is to have each airport’s local law enforcement and/or private/hired security personnel provide both their officers and TSA personnel with a written policy concerning medical cannabis. Because local law enforcement must respect the rights of Hawaii’s patients and caregivers to transport cannabis in compliance with Hawai’i statute, whenever a valid patient identification certificate is presented to TSA security screeners, and the amount of cannabis does not exceed the legal limits of an adequate supply, the patient or caregiver must be allowed to continue on to their flight. In these cases, local law enforcement need not be summoned nor even alerted, and the patient’s or caregiver’s possession of cannabis should be of no concern.

Currently, Alameda County, California has issued such a memo to the Sheriff's Deputies who provide security at Oakland International Airport.²² In Hawai'i, a similar memo should be issued and should also be sent to local non-airport security checkpoints such as courthouses and arena events. Further research is needed to discover the appropriate entity to issue such a policy which could be done either at the county or state level. A resolution from the State Legislature could be the means of mandating action on this issue.

b. Define "Transportation" in H.R.S. § 329-121

The Hawai'i State Legislature may want to consider revising Section 329-121 to specifically define "transportation" to address possession, delivery, control, acceptance and/or receipt of cannabis and/or cannabis paraphernalia for the purpose of transporting to or from a caregiver to a patient, a patient to a caregiver, a caregiver to a caregiver, or a patient to a patient from one island to another island.

Ideally, patients' right to travel with their medical cannabis should eventually ensure that patients' right to travel from the State of Hawai'i to another jurisdiction that allows for cannabis possession or from another jurisdiction that allows for cannabis possession to the State of Hawai'i. Any such new definitions to HRS 329-121 should also wholly eliminate the limiting definition of "distribution." The term "acquisition" should be defined also, for now it seems that Hawai'i police have not yet warmed up to the idea of following Hawai'i State law and allowing any actual place or actual means to safely, conveniently and affordably acquire medical cannabis.

c. Establish an Affirmative Right to Travel

Only the Hawai'i County Police Department has had protocols for investigating medical and religious use of cannabis and they've only had them since 2002. These rules are not always followed, but they are in place. These protocols could be expanded to include transportation, and could be based on "open container" laws relating to alcohol. (HRS §§ 291-3.1 and 291-3.3) This law allows alcohol to be in the trunk or another area inaccessible to a driver, but does not allow it to be in a utility or glove compartment. The state legislature could pass a resolution asking the other counties to adopt similar policies.

Appendix J contains contact information and information about the missions of the Department of Public Safety's Sheriff's Division and of the Narcotics Enforcement Division (which oversees Hawai'i's medical marijuana program.)

²² See Appendix O for Oakland International Airport Police Services Policy and Procedure memo re: Medical Marijuana at the Oakland International Airport Checkpoints.

D. Physician Issues

Mandate: To examine all issues and obstacles faced by physicians who may wish to participate in the medical cannabis program.

Members:

Gary L. Greenly, OD – MCWG member
Charlie Webb, MD – MCWG member
Sandy Webb, RN – MCWG member
David Barton, MD – MCWG member
Anne E. Beidel, MD – MCWG member
Jeanne Ohta – volunteer

1. Findings

a. Patient Certification

1. Inability to Immediately Certify Patients

It currently takes NED 60 or more days to process applications. It is inhumane to have to tell patients they will need to wait 60 days or more to receive their patient cards. Patients are anxious and frequently call their physician's office to ask "where's my card?" Seriously ill patients need their certification cards in a timely manner.

Most states solve this problem with temporary cards issued by the physician. Polled physicians unanimously agree that care would be greatly improved if a physician could issue some sort of temporary document at the time of the office visit.²³ Some physicians have issued a letter to each patient stating that an application has been submitted. However, one physician was concerned that he should not be an agent of the state and issuing a certificate could make him an agent.

The current Hawai'i State Administrative Rules requires that NED issue a receipt for the application fee when the application is received. This receipt is meant to serve as a temporary registration card. No physician has ever received such a receipt.

2. Recommendation – Establish Presumptive Eligibility

Since NED is apparently unable to provide an immediate temporary document, one solution would be to have presumptive eligibility with a letter from the physician saying that an application for a certificate has been submitted.

²³ Polled physicians were contacted by the committee based on their known participation in the medical cannabis program.

b. NED Oversight

1. Uncooperative/Inappropriate Responses

Physicians report a range of experiences with NED employees (who administer the Hawai'i program). Some physicians report that NED has been responsive, but that reduced staffing at the department has affected their ability to learn the status of patients' applications.

Although physicians sympathize that NED has been forced to do something that is directly opposed to their traditional mission, it is still disconcerting when some physicians' queries to NED are met with barely cooperative – or antagonistic – responses. Surely this is not in the best interests of patients or physicians. In 2005 there was a troubling incident upon the death of Dr. William Wenner, a Hawai'i Island physician who had certified scores of patients. His patients were sent a letter from NED telling them that their certification cards were no longer valid.²⁴ This caused widespread consternation among patients and a scramble to find replacement physicians who were few and far between in that geographically huge county.

2. Recommendation – Transfer Oversight of the Medical Cannabis Program to the Department of Health

We recommend transferring the program to the Department of Health to benefit patients and caregivers and facilitate a medical model, similar to what is used in New Mexico, to ensure confidentiality of the program. Polled medical cannabis physicians unanimously agree that DOH should administer the medical cannabis program. Physicians were also unanimous in support of using 100% of the state certification fees to fund the certification process.²⁵

c. Medical Qualifications

1. List of Qualifying Conditions is Too Restrictive

Hawaii's first attempt at Medical Marijuana legislation was a good one and probably covers a majority of potential patients (chronic pain, spasms, cancer, glaucoma, seizures, HIV, etc.)

However, cannabis could help many other patients with the following disorders:

- sleep disorders
- mood disorders (bipolar disorder, ADHD, and others)
- Post Traumatic Stress Disorder (PTSD)
- Asthma

2. Recommendation – Expand the List of Qualifying Conditions

Table I. lists the qualifying conditions in each state program. Many states allow for conditions not currently authorized by the Hawai'i program and we recommend that Hawai'i expand their list of qualifying conditions.

²⁴ See Appendix P for NED letter to Dr. Wenner's patients.

²⁵ See Appendix Q for NED Physicians' Guidelines.

Table I. (Compiled by Sandy Webb, R.N.)

State-by-State Comparison of Medical Conditions Qualifying for Medical Use of Cannabis

<i>State</i>	<i>Qualifications:</i>
Alaska	cachexia cancer chronic pain epilepsy/seizures glaucoma HIV/AIDS MS muscle spasticity nausea
California	“Patients diagnosed with any debilitating illness where medical use of marijuana has been deemed appropriate and has been recommended by a physician” cachexia cancer chronic pain epilepsy/seizures glaucoma HIV/AIDS MS muscle spasticity nausea migraine headache
Colorado	cachexia cancer chronic pain epilepsy/seizures glaucoma HIV/AIDS MS muscle spasticity nausea chronic nervous disorders
<u>Hawai‘i</u>	cachexia cancer chronic pain epilepsy/seizures glaucoma HIV/AIDS MS muscle spasticity nausea

	Crohn's disease
Maine	<p> cachexia cancer chronic pain epilepsy/seizures glaucoma HIV/AIDS MS muscle spasticity nausea Crohn's disease Hepatitis C ALS agitation of Alzheimer's DZ nail patella syndrome chronic or debilitating disease or medical condition or its treatment that produces intractable pain </p>
Maryland	<p> cachexia cancer chronic pain epilepsy/seizures glaucoma HIV/AIDS MS muscle spasticity nausea Crohn's disease Hepatitis C ALS agitation of Alzheimer's Disease nail patella syndrome chronic or debilitating disease or medical condition or its treatment that produces intractable pain </p>
Michigan	<p> Cancer Glaucoma Positive status for HIV AIDS Hepatitis C ALS (Lou Gehrig's Disease) Crohn's Disease Agitation of Alzheimer's Disease Nail patella cachexia or wasting syndrome severe and chronic pain nausea </p>

	<p>seizures, including but not limited to those characteristic of epilepsy severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis</p>
Montana	<p>cachexia chronic pain nausea epilepsy/seizures muscle spasticity MS Crohn's disease</p>
Nevada	<p>HIV/AIDS cancer glaucoma cachexia muscle spasticity epilepsy/seizures nausea chronic pain</p>
New Mexico	<p>Severe chronic pain painful peripheral neuropathy intractable nausea/vomiting severe anorexia/cachexia Hepatitis C currently receiving antiviral treatment Crohn's disease PTSD ALS cancer glaucoma MS Damage to the nervous tissue of the spinal cord with intractable spasticity epilepsy/seizures HIV/AIDS Hospice Patients</p>
Oregon	<p>cachexia cancer chronic pain epilepsy/seizures glaucoma HIV/AIDS MS muscle spasticity nausea</p>

Rhode Island	cachexia cancer chronic pain epilepsy/seizures glaucoma HIV/AIDS MS muscle spasticity nausea Hepatitis C agitation of Alzheimer's Disease
Vermont	cachexia severe pain nausea seizures
Washington	cachexia cancer intractable pain (defined as pain unrelieved by standard treatment or medication) epilepsy/seizures glaucoma HIV/AIDS MS

d. End of Life Care

1. Certification Process Takes Too Long for Terminally Ill Patients

Several committee members also suggest that medical cannabis be available for end-of-life care for patients who have been diagnosed with terminal illnesses. New Mexico’s program, for example, allows medical cannabis for hospice patients.

2. Recommendation – Establish Presumptive Eligibility for Hospice-Certified Patients

Since there is a clear certification process and criteria for a patient to qualify for hospice care and since hospice care is usually limited to six months; it is suggested that hospice certification be used to allow a patient presumptive eligibility for medical cannabis. This would allow a physician to notify NED that s/he has certified a hospice patient for the use of medical cannabis (e.g. a “temporary certificate” or an “end-of-life certificate.”) It would be inappropriate for hospice patients to have to wait to receive their certification cards for the current two-month processing time.

e. Adding Covered Medical Conditions

1. No Process Whereby Doctors Can Add to the List of Covered Medical Conditions

In everyday medicine, it is left to doctors’ discretion to recommend whichever treatments they think would be most beneficial in comparison with the risks (“assessing the risk/benefit ratio.”) Traditional pharmaceutical treatments for sleep disorders and for many mood disorders carry a very poor risk/benefit ratio. For example, most sleep medicines are addicting and/or leave people groggy in the morning, while many mood disorder drugs (Lithium, depakote, benzodiazepines, amphetamines, and anti-depressants) are dangerous and/or addicting. In comparison, cannabis is minimally harmful (safer than Tylenol and aspirin) and carries a very low addiction risk.

Other states have successfully added new conditions such as Alzheimer-related anxiety to their list of allowable conditions. Although Hawaii’s law currently provides a method to add additional conditions, DOH has not promulgated administrative rules to initiate the process. DOH has stated that they are not required to do so.

2. Recommendations – Develop a Process for Adding New Conditions

The list of qualifying medical conditions could be expanded by polling doctors who certify patients for Medical Cannabis (a problem with this approach is that the list of participating physicians is held confidentially by NED).

A petition process currently in use in Alaska, Colorado, New Mexico Washington, and Michigan could be adopted. (Table II. provides an overview of the various states processes.)

Qualifications could be determined at the discretion of each physician's assessment of risk/benefit ratio, as is done currently with all other treatments in medicine which include the use of far more dangerous drugs such as: opiates for pain, tranquilizers for mood disorders, and amphetamines for ADHD.

Most medical cannabis physicians polled think physician discretion should be allowed as is done in all other practice of medicine. One physician disagrees because of concerns that physician licenses could be jeopardized if their certifications are judged to be too liberal.

Table II.
Process for Adding New Conditions (Compiled by Jeanne Ohta)

State	Description of Process
Alaska	<p>Other conditions are subject to approval by the Alaska Department of Health and Social Services: the department shall accept for consideration physician or patient initiated petitions to add debilitating medical conditions; after hearing, shall approve or deny the petitions within 180 days of submission. The denial of a petition shall be considered a final agency action subject to judicial review.</p> <p>At its discretion, the department will convene a group of qualified individuals to evaluate and make recommendations on the petition</p>

	<p>to the department. The group must include at least two physicians, a representative from the Department of Public Safety, and a representative from the Department of Law. When considering a petition, the department will, and any group convened by the department shall evaluate whether</p> <p>1) medical indicators establish that</p> <p>a) the condition listed in the petition is debilitating;</p> <p>b) the medicinal use of marijuana is likely to benefit the patient with that condition; and</p> <p>c) the condition can be accurately diagnosed by a physician; and</p> <p>2) in the discretion of the department, other factors provide medical support for evaluating the petition..</p>
California	N/A
Colorado	Other conditions are subject to approval by the Colorado Board of Health: The state health agency shall accept physician or patient initiated petitions to add debilitating medical conditions and after such hearing as the state health agency deems appropriate, shall approve or deny such petitions within 180 days of submission.
Hawai'i	No approved process for adding conditions.
Maine	New medical conditions cannot be added
Michigan	Rule 333.131 requires the Michigan Department of Community Health (MDCH) to have a procedure for accepting petitions from the public to include additional medical conditions and treatments. The procedure must include public notice of hearings on each petition, opportunities for public input, and a reasonable timeline (180 days) for approval or denial.
Montana	Other conditions adopted by the rules of the Department of Public Health and Human Services.
Nevada	Other conditions are subject to approval by the health division of the state Department of Human Resources.
New Mexico	<p>The New Mexico's Department of Health's Medical Advisory Board holds hearings on petitions to add new conditions. The Board is comprised of eight board-certified physicians which makes recommendations to the Department's Health Secretary who makes the final decision on all petitions. The Health Secretary has added eight medical conditions based on recommendations from the Medical Advisory Board, a review of scientific literature that shows the conditions could be helped by medical Cannabis and the purpose of the Lynn and Erin Compassionate Use Act to provide relief from pain and suffering associated with debilitating medical conditions.</p> <p>On December 11, 2009, the board reviewed five petitions for the following conditions: Hepatitis C undergoing non-antiviral treatment, cluster headaches, Ankylosing Spondylitis, Bipolar Disorder and Obsessive Compulsive Disorder, and Blepharospasm. A decision had not been announced by December 31, 2009.</p>
Oregon	333-008-0090-Addition of Qualifying Diseases or Medical Conditions

(1) The Department shall accept a written petition from any person requesting that a particular disease or condition be included among the diseases and conditions that qualify as debilitating medical conditions under section 333-008-0010 of these rules and be added to the list.

(2) The Department shall, within 14 days of receipt of the petition, send a letter by certified mail requesting the petitioner to provide, if possible:

- (a) An explanation for why the condition should be included;
- (b) Any literature supporting the addition of the condition to the list;
- (c) Letters of support from physicians or other licensed health care professionals knowledgeable about the condition; and,
- (d) Suggestions for potential expert panel members.

(3) The State Public Health Officer or designee may make a final determination that a petition is frivolous and deny the petition without further review.

(4) If the petition is not denied under section (3) of this rule, the Department shall appoint an expert panel of five to seven individuals to review a petition. The members of the panel shall include the State Public Health Officer or designee, other physicians licensed under ORS 677, at least one patient, at least one patient advocate, and other professionals knowledgeable about the condition being considered.

- (a) If the petitioner so desires, she or he shall be given the opportunity to address the panel in person or by telephone.
- (b) If the petitioner so desires, his or her confidentiality shall be strictly maintained.

(5) The Department shall submit the written petition to the expert panel, which shall make recommendations to the Department regarding approval or denial.

- (a) The members of the panel may examine medical research pertaining to the petitioned condition, and may gather information (in person or in writing) from other parties knowledgeable about the condition being considered.
- (b) The panel members will submit individual recommendations to the State Public Health Officer, and the meetings of the panel will not be considered to be public hearings.

(6) The Department will make a final determination on a petition within 180 days of receipt of the petition.

(7) Denial of a petition shall be considered a final Department action subject to judicial review.

(8) In cases where the condition in a person's petition is the same as, or is, as determined by the Department's State Public Health Officer, substantially equivalent to a condition that has already been denied in a previous determination, the Department may similarly deny the new petition unless new scientific research supporting the request is brought forward.

Stat. Auth.: ORS 475.338
 Stats. Implemented: ORS 475.300 - 475.346

Rhode Island	Other conditions are subject to approval by the Rhode Island Department of Health
Vermont	New medical conditions cannot be added
Washington	69.51A.070 The Washington state medical quality assurance commission in consultation with the board of osteopathic medicine and surgery, or other appropriate agency as designated by the governor, shall accept for consideration petitions submitted to add terminal or debilitating conditions to those included in this chapter. In considering such petitions, the Washington state medical quality assurance commission in consultation with the board of osteopathic medicine and surgery shall include public notice of, and an opportunity to comment in a public hearing upon, such petitions. The Washington state medical quality assurance commission in consultation with the board of osteopathic medicine and surgery shall, after hearing, approve or deny such petitions within one hundred eighty days of submission. The approval or denial of such a petition shall be considered a final agency action, subject to judicial review. [2007 c 371 § 7; 1999 c 2 § 9 (Initiative Measure No. 692, approved November 3, 1998).]

f. Certification Period

1. Patients with Incurable Conditions are Required to Recertify Every Year

Some qualifying conditions are currently incurable (HIV, many cancers, most arthritis, etc.) yet these patients and their doctors are required to go through the recertification process every year.

2. Recommendation – Allow for Permanent or Long-Term Certification for Patients with Incurable Conditions

Polled medical Cannabis physicians unanimously agree that they should be able to certify patients with such chronic conditions periods longer than the current one year.

g. Cannabis Education

1. Educational Material from the State is Not Available to Patients, Caregivers and Physicians

It has been widely acknowledged that cannabis is safer than many pharmaceutical drugs used to treat chronic conditions. Physicians are concerned that both the public and policy makers must be made aware of the safety record of cannabis.

Options for pain medications are limited and not without dangers. Non-steroidal anti-inflammatory drugs, or NSAIDs (aspirin, ibuprofen, Aleve, etc.), hospitalize 100,000 people per year with bleeding ulcers and/or kidney failure, of which about 16,000 die. Overdoses of Tylenol cause liver failure and are very lethal. Overdoses of opiates (Vicodin, Percocet, Oxycontin, morphine, etc) cause respiratory arrest and death. Yet no lethal dose is known for

cannabis and no deaths are attributable to cannabis despite its being used by millions of people. As a famous finding of the 1990's stated, "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man. By any measure of rational analysis marijuana can be safely used within a supervised routine of medical care."²⁶

2. Recommendation – Medical Cannabis Information Should be Made Available by the State to Patients, Caregivers and Physicians
- h. Patients' (In)ability To Acquire Cannabis Medicine
 1. Physicians are Unable to Assist Patients with Obtaining Cannabis Medicine

(Although this topic is part of the Patient Issues Committee report, the physicians believe that it is important enough to submit their own comments.)

NED requires that physicians sign a statement on each certification application that they will not assist patients in any way to acquire cannabis. It is embarrassing and obstructionist for physicians to be forced to tell patients that they may not in any way help them find or acquire their cannabis medication. All other recommended medications are immediately available to patients either over-the-counter or by prescription at the pharmacy.

The only cannabis medication available to patients for the first five or six months is whatever they can find illegally on the black market where there is no quality control or assurance of purity. Colorado courts have concluded that patients are legally required to break the law in order to acquire their medication.

The obvious solution is to have cannabis dispensaries. At least five other states have legal dispensaries. Otherwise, patients must buy cannabis illegally on the black market or plant seeds (also obtained illegally) and wait at least three more months (in addition to their two month wait for the State of Hawaii's certification card) for their medication.

2. Recommendations – eliminate physician statement and establish government-run distribution system

Polled medical cannabis physicians unanimously agree that physicians should not be required to sign that they will not in any way help patients find their medicine. Further, all agree that Medical Cannabis patients deserve to have dispensaries available for medication, seeds, clones, etc.

²⁶ Young, Francis L., DEA Administrative Law Judge, *Opinion and Recommended Ruling, Finding of Fact, Conclusion of Law and Decision*, 1998.

E. Public Safety Issues

Mandate: To examine all issues surrounding law enforcement and the medical cannabis program

Sub Committee Members:

Pam Lichty (Subcommittee Chair) – MCWG co-chair

Laurie Temple – MCWG co-chair

Don Eads, BA, MA – volunteer

Robert Bacher – volunteer

1. Introduction

Public safety is best served by cultivating an excellently run statewide medical cannabis patient-centered approach by everyone involved. Although other states like California²⁷ and Colorado²⁸ provide models whose format we can borrow from, Hawai`i is unique geographically and culturally, particularly in terms of the tropical island climate and the ohana (extended family) lifestyle. Patients statewide must be insured safe and legal access to an adequate supply. If patients lack safe access, both patient safety and public safety are potentially at risk. The following public safety recommendations are adaptable to all current bills concerning medical cannabis now before the legislature. To care for our patients with aloha every day is our common goal.

Because the Medical Cannabis Task Force was never convened by the Governor, state agencies like the Narcotics Enforcement Division (which oversees the medical cannabis program) did not participate in our research or report or respond to our requests for interviews. Therefore, this subcommittee looked to media sources for Hawai`i public safety officials' stated concerns about the medical cannabis program. The statements that we found from government officials indicate that there is overwhelming amount of misinformation and confusion concerning the use of medical cannabis and law enforcement's duties with regard to upholding conflicting state and federal laws.

2. Findings

a. Patient Safety

1. Allowing patients to grow their own medical cannabis puts their safety at risk.

In a *Honolulu Weekly* interview, Keith Kamita, NED Administrator, and Major Frank Fujii, Honolulu Police Department spokesperson, detailed their concerns about the medical cannabis program, particularly with regard to patients' growing their own medical cannabis. The article stated, "United against cannabis, Kamita and Fujii also agree that though the current law requires it, it can be dangerous for patients to grow their own. 'Anytime you

²⁷ See <http://www.cdph.ca.gov/programs/MMP/Pages/Medical%20Marijuana%20Program.aspx> for program information.

²⁸ See <http://www.cdph.state.co.us/hs/medicalmarijuana/> for program information.

grow marijuana there is a strong probability that other people will learn of the activity. This increases your risk to fall victim to robbery, burglary, and/or theft,' Fujii said."²⁹

2. Recommendations: establish a government-run distribution system and adopt policies and procedures to protect patients' privacy

A government-run distribution system would alleviate law enforcement officials' concerns about the risks to patient and caregiver safety because patients would no longer grow their own medical cannabis.

Adopting policies and procedures to protect patients' privacy would add an additional layer of safety because patients' medical and other information would not be available to those who would misuse the information.

b. Illegal Drug Use

1. Fear That Use of Medical Cannabis will Lead to Patients' Abuse of Illegal Drugs

During the same interview, Kamita called marijuana and alcohol "gateway drugs," which may indicate that he has fears that medical cannabis use may lead patients to use more dangerous illegal drugs.³⁰ Further, Thomas Phillips, Maui Chief of Police Chief, testified in January 2008 against a medical cannabis task force saying, "It is no wonder that we consistently rank in the top seven states in the nation in regards to marijuana plants eradicated, and consequently have one of the worst crystal methamphetamine problems in the nation."³¹

2. Recommendation – Provide Education on Medical Cannabis to Law Enforcement Officers

We recommend that the Legislature and/or the MCWG ensure that law enforcement officials are provided with the most recent scientific and other studies and information on patients' use of medical cannabis.

c. Legality of Medical Cannabis Under Federal Law

1. Fear that Government and Law Enforcement Agencies Are Not Upholding Their Duties Under Federal Law

It is apparent that the current state administration and law enforcement agencies are uncertain about the status of medical cannabis under federal law and apprehensive that they may not be upholding their duties under federal law. For instance, in her statement vetoing a bill establishing a medical cannabis task force, Governor Lingle stated "The bill is objectionable because it is an exercise aimed at finding ways to circumvent federal law. The use of marijuana, even medical marijuana, is illegal under federal law. It is, therefore, inappropriate

²⁹ Mebel, Greg, *Maui Owie: Crackdown on the Valley Isle*, Honolulu Weekly, Dec. 31, 2008. Also available at <http://honoluluweekly.com/feature/2008/12/maui-owie/>.

³⁰ *Id.*

³¹ *Id.*

for the state to recommend ways to maintain or increase the supply of marijuana, to make recommendations regarding the development of marijuana-growing facilities, or to seek ways to circumvent federal prohibitions regarding the transport of marijuana.”³² Fujii agreed, stating that “The HPD will continue to take a strong stance against the medicinal use of marijuana because it is still a violation of federal law. The U.S. Supreme Court has held that smoked marijuana is not ‘medicine.’ Further, the Food and Drug Administration has never approved smoked marijuana as a medicine.”³³

2. Recommendation – the Legislature Should Ask For a Legal Opinion from the Attorney General and County Corporation Counsels

Given that even the highest ranking official in Hawai‘i is concerned about the legality of the medical cannabis program under federal law, it is imperative that law enforcement agencies receive clarity and guidance so that they can be confident that they are properly exercising their duties. To this end, we recommend that the Legislature ask for a legal opinion from the Hawai‘i State Attorney General and County Corporation Counsels so as to clarify the duties of law enforcement agencies under federal and state law with regard to medical cannabis.

- d. Illegal Access to Medical Cannabis

1. Fear that Non-Patients and Patients Without A Legitimate Need Will Have Access to Cannabis

Kamita also noted that more marijuana is showing up in schools, possibly because of its use for medical patients, stating “Kids can go see Grandpa and go see a harvest. We’ve just got to be very careful with this.”³⁴ Further, he questioned the legitimacy of some patients’ needs.³⁵ According to the *Honolulu Weekly*, many police officers cite cases where licensed caregivers have sold medical marijuana to unlicensed users and dealers.³⁶

2. Recommendation – Enforce Existing Laws and Educate Patients and Caregivers

The current law provides penalties for law violations and should be used by law enforcement to ensure compliance. Providing more education to patients and caregivers about the law and penalties may help to lower illegal access to medical cannabis.

³² Fujimoto, Lila, ‘Careful What you Ask For,’ Says Police Chief, The Maui News, Feb. 8, 2009. Also available at <http://www.mauinews.com/page/content.detail/id/514619.html>.

³³ Mebel, Greg, *Maui Owie: Crackdown on the Valley Isle*, Honolulu Weekly, Dec. 31, 2008. Also available at <http://honoluluweekly.com/feature/2008/12/maui-owie/>.

³⁴ Altonn, Helen, *Lawmaker Addressing Medical Marijuana*, Feb. 1, 2008. Also available at <http://archives.starbulletin.com/2008/02/01/news/story09.html>.

³⁵ Hurley, Timothy, *Medical Marijuana Law Yet To Realize Potential*, July 29, 2002. Also available at <http://the.honoluluadvertiser.com/article/2002/Jul/29/In/In06a.html>.

³⁶ Mebel, Greg, *Maui Owie: Crackdown on the Valley Isle*, Honolulu Weekly, Dec. 31, 2008. Also available at <http://honoluluweekly.com/feature/2008/12/maui-owie/>.

e. Inappropriate Certification by Physicians

1. Belief that Physicians are Certifying Patients for Medical Cannabis Use for Profit Rather Than Legitimate Medical Use

Kamita believes that some doctors on the Big Island are involved in certifying patients for medical marijuana use “strictly as a business.”³⁷

2. Recommendation – Enforce Existing Law and Ethical Obligations

Current law and ethical rules for physicians should be enforced to ensure that physicians are not abusing their ability to certify patients.

³⁷ Dayton, Kevin, *Fewer Register to Use Medical Marijuana*, January 2, 2007. Also available at <http://the.honoluluadvertiser.com/article/2007/Jan/02/In/FP701020346.html>.

IV. Summary of Recommendations

MCWG's subcommittees developed many recommendations to improve Hawaii's medical marijuana program. While some of these would require legislative action (either a bill or a resolution), some require only a change to administrative rules. Some may only require a policy change from the relevant agency or the issuance of public education materials. There was a great deal of overlap in the recommendations from each subcommittee, but four recommendations rose to the top because so many of the subcommittees awarded them high priority.

A. Highest Priority Recommendations

1. Create a distribution system so that patients no longer have to grow it themselves or resort to the black market to obtain their medicine;
2. Increase the allowable number of plants and the amount of usable cannabis to ensure that patients have an adequate supply of their medicine;
3. Allow caregivers to care for at least five patients to ensure that patients are assured of an adequate supply and a competent caregiver; and
4. Transfer medical cannabis program oversight from the Department of Public Safety to the Department of Health.

B. Additional Recommendations

1. Make the program more accessible and "user friendly"
 - a. Increase patient confidentiality (e.g. remove addresses from certification card) and implement electronic management solutions;
 - b. Establish presumptive eligibility (so that a patient with completed paperwork is assumed to be certified pending determination by NED) and expedite patient certification;
 - c. Notify patients when expiration of certification is approaching;
 - d. Expand time limit for informing NED of changes to patient information (currently change of address notification must be done within five working days);
 - d. Post program forms and other accurate program information on the NED website in a timely manner;
 - f. Establish referral list of physicians; and
 - g. Provide advance notice of program changes to patients and physicians.
2. Facilitate inter-island transport of medical cannabis
 - a. Develop and implement policies to permit such travel by certified patients and caregivers;
 - b. Direct the counties and relevant agencies to clarify, issue, and disseminate policies on traveling with medical cannabis;
 - c. Develop protocols for packaging and labeling medicine for air

- travel;
 - e. Establish written policies and procedures and educate law enforcement and security personnel on travelling with medical cannabis;
 - f. Establish an affirmative right to travel; and
 - g. Define transportation in H.R.S. § 329-121.
3. Improve the healthcare aspects of the program
- a. Expand list of covered conditions and create a protocol for adding new covered medical conditions;
 - b. Expedite coverage for hospice patients by establishing presumptive eligibility;
 - c. Permit permanent and/or extended certification for patients with chronic conditions;
 - d. Allow physicians to provide patients with information about how to access medical cannabis;
 - e. Provide timely and accurate information about the medical cannabis program to physicians; and
 - f. Amend definition of “adequate supply” and other terms that fail to account for different medical cannabis strains/forms.
4. Address law enforcement concerns
- a. Compensate patients for unauthorized seizures of medical cannabis;
 - b. Establish reciprocity with other states with medical cannabis programs; and
 - c. Obtain a legal opinion from the Attorney General and/or Corporation Counsels clarifying law enforcement duties under both federal and state law.
5. Study long term problems for future action
- a. Clarify workplace/union rules and family law guidelines regarding medical cannabis use;
 - b. Examine problems for renters and those in public housing, especially those with federal subsidies;
 - c. Research policies of various types of residential facilities (*e.g.*, nursing homes and hospices);
 - d. Explore methods of disseminating information of program details, growing techniques, etc.; and
 - e. Investigate access to insurance coverage for program participants.
6. Convene the Medical Cannabis Task Force and/or MCWG for the foreseeable future to identify and help to implement strategies, both legislative and administrative.

V. Conclusion

The Medical Cannabis Working Group is pleased to present the results of its extensive research and deliberations to the 2010 Hawai'i State Legislature.

Everyone in this extremely diverse group agreed that Hawaii's medical marijuana program is in need of very significant improvements. There have been no changes made to the program since its enactment in 2000.

During that time many things have changed. More and more states have authorized medical cannabis and the more recent ones – such as New Mexico and Rhode Island - have incorporated many refinements. We also cannot overlook the recent changes in the federal stance, which provide an opportunity for Hawai'i to adopt some of the state-of-the-art provisions of other states' programs without worrying about the federal response.

Indeed there is no better time to re-visit, update and improve Hawaii's program. The more than 5,700 patients currently registered are counting on us all to do just that. The members and contributors of the Medical Cannabis Working Group hope that this report will enable policymakers to determine the directions the program should move in utilizing the very specific recommendations and supporting materials included here.

APPENDICES

- A. Act 228
- B. Hawaii Administrative Rules Chapter 23-202
- C. Department of Public Safety's July 7, 2008 letter to patients
- D. Governor Lingle's July 8, 2008 H.B. 2675 veto message
- E. Act 29 of 2009
- F. Governor Lingle's July 6, 2009 S.B. 1058 veto message
- G. Eddy, Mark. *Medical Marijuana: Review and Analysis of Federal and State Policies*, 17-23 (March 31, 2009)
- H. *Access, Distribution, and Security Components of State Medical Marijuana Program*," by Lance Ching, Legislative Reference Bureau, 2009
- I. Medical Cannabis Working Group Talk Story Notes, October 27, 2009
- J. Hawai'i Medical Cannabis Working Group Questionnaire, October, 2009
- K. Questionnaire Result Compilation, January 5, 2010
- L. Suzanne M. Klinker, Medical Center Director, Department of Veterans Affairs, June 19, 2009 letter to Martin H. Chilcutt, Veterans for Medical Marijuana Access
- M. Narcotics Enforcement Division Patient Information for the Authorized Medical use of Marijuana
- N. Department of Public Safety's Sheriff's Division description
- O. Department of Public Safety's Narcotics Enforcement Division description
- P. Airport Police Services Policy and Procedure: Medical Marijuana at the Oakland International Airport Checkpoints, December 11, 2007
- Q. Keith Kamita, Administrator, Narcotics Enforcement Division, December 9, 2005 letter to the patients of Dr. William Wenner
- R. Narcotics Enforcement Division Physician's Guideline for Completing Hawaii's Written Certification/Registry Identification Forms for the Medical Use of Marijuana

APPENDIX A

REPORT TITLE:

Medical Use of Marijuana

DESCRIPTION:

Allows for the acquisition, possession, and use of marijuana for medical purposes. (SB862 HD1)

THE SENATE
TWENTIETH LEGISLATURE, 1999
STATE OF HAWAII

S.B. NO.

862

S.D. 2
H.D. 1

A BILL FOR AN ACT

RELATING TO MEDICAL USE OF MARIJUANA.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature finds that modern medical
2 research has discovered a beneficial use for marijuana in
3 treating or alleviating the pain or other symptoms associated
4 with certain debilitating illnesses. There is sufficient medical
5 and anecdotal evidence to support the proposition that these
6 diseases and conditions may respond favorably to a medically
7 controlled use of marijuana.

8 The legislature is aware of the legal problems associated
9 with the legal acquisition of marijuana for medical use.
10 However, the legislature believes that medical scientific
11 evidence on the medicinal benefits of marijuana should be
12 recognized. Although federal law expressly prohibits the use of
13 marijuana, the legislature recognizes that a number of states are
14 taking the initiative in legalizing the use of marijuana for
15 medical purposes. Voter initiatives permitting the medical use
16 of marijuana have passed in California, Arizona, Oregon,
17 Washington, Alaska, Maine, Nevada, and the District of Columbia.

18 The legislature intends to join in this initiative for the

19 health and welfare of its citizens. However, the legislature
20 does not intend to legalize marijuana for other than medical

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S.B. NO. 862
S.D. 2
H.D. 1

1 purposes. The passage of this Act and the policy underlying it
2 does not in any way diminish the legislature's strong public
3 policy and laws against illegal drug use.

4 Therefore, the purpose of this Act is to ensure that
5 seriously ill people are not penalized by the State for the use
6 of marijuana for strictly medical purposes when the patient's
7 treating physician provides a professional opinion that the
8 benefits of medical use of marijuana would likely outweigh the
9 health risks for the qualifying patient.

10 SECTION 2. Chapter 329, Hawaii Revised Statutes, is amended
11 by adding a new part to be appropriately designated and to read
12 as follows:

13 **"PART . MEDICAL USE OF MARIJUANA**

14 **§329-A Definitions.** As used in this part:

15 "Adequate supply" means an amount of marijuana jointly
16 possessed between the qualifying patient and the primary
17 caregiver that is not more than is reasonably necessary to assure
18 the uninterrupted availability of marijuana for the purpose of
19 alleviating the symptoms or effects of a qualifying patient's
20 debilitating medical condition; provided that an "adequate

21 supply" shall not exceed three mature marijuana plants, four
22 immature marijuana plants, and one ounce of usable marijuana per
23 each mature plant.

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S.B. NO.

862

S.D. 2

H.D. 1

1 "Debilitating medical condition" means:

2 (1) Cancer, glaucoma, positive status for human
3 immunodeficiency virus, acquired immune deficiency
4 syndrome, or the treatment of these conditions;

5 (2) A chronic or debilitating disease or medical condition
6 or its treatment that produces one or more of the
7 following:

8 (A) Cachexia or wasting syndrome;

9 (B) Severe pain;

10 (C) Severe nausea;

11 (D) Seizures, including those characteristic of
12 epilepsy; or

13 (E) Severe and persistent muscle spasms, including
14 those characteristic of multiple sclerosis or
15 Crohn's disease;

16 or

17 (3) Any other medical condition approved by the department
18 of health pursuant to administrative rules in response
19 to a request from a physician or potentially qualifying
20 patient.

21 "Marijuana" shall have the same meaning as "marijuana" and
22 "marijuana concentrate" as provided in sections 329-1 and 712-
23 1240.

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	H.D. 1

1 "Medical use" means the acquisition, possession,
2 cultivation, use, distribution, or transportation of marijuana or
3 paraphernalia relating to the administration of marijuana to
4 alleviate the symptoms or effects of a qualifying patient's
5 debilitating medical condition. For the purposes of "medical
6 use", the term distribution is limited to the transfer of
7 marijuana and paraphernalia from the primary caregiver to the
8 qualifying patient.

9 "Physician" means a person who is licensed under
10 chapters 453 and 460, and is licensed with authority to prescribe
11 drugs and is registered under section 329-32. "Physician" does
12 not include physician's assistant as described in section 453-
13 5.3.

14 "Primary caregiver" means a person, other than the
15 qualifying patient and the qualifying patient's physician, who is
16 eighteen-years-of-age or older who has agreed to undertake
17 responsibility for managing the well-being of the qualifying
18 patient with respect to the medical use of marijuana. In the
19 case of a minor or an adult lacking legal capacity, the primary

20 caregiver shall be a parent, guardian, or person having legal
21 custody.

22 "Qualifying patient" means a person who has been diagnosed
23 by a physician as having a debilitating medical condition.

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	H.D. 1

1 "Usable marijuana" means the dried leaves and flowers of the
2 plant Cannabis family Moraceae, and any mixture of preparation
3 thereof, that are appropriate for the medical use of marijuana.
4 "Usable marijuana" does not include the seeds, stalks, and roots
5 of the plant.

6 "Written certification" means the qualifying patient's
7 medical records or a statement signed by a qualifying patient's
8 physician, stating that in the physician's professional opinion,
9 the qualifying patient has a debilitating medical condition and
10 the potential benefits of the medical use of marijuana would
11 likely outweigh the health risks for the qualifying patient. The
12 department of public safety may require, through its rulemaking
13 authority, that all written certifications comply with a
14 designated form. "Written certifications" are valid for only one
15 year from the time of signing.

16 **§329-B Medical use of marijuana; conditions of use.** (a)

17 Notwithstanding any law to the contrary, the medical use of
18 marijuana by a qualifying patient shall be permitted only if:

19 (1) The qualifying patient has been diagnosed by a

20 physician as having a debilitating medical condition;
21 (2) The qualifying patient's physician has certified in
22 writing that, in the physician's professional opinion,
23 the potential benefits of the medical use of marijuana

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1 would likely outweigh the health risks for the
2 particular qualifying patient; and
3 (3) The amount of marijuana does not exceed an adequate
4 supply.
5 (b) Subsection (a) shall not apply to a qualifying patient
6 under the age of eighteen years, unless:
7 (1) The qualifying patient's physician has explained the
8 potential risks and benefits of the medical use of
9 marijuana to the qualifying patient and to a parent,
10 guardian, or person having legal custody of the
11 qualifying patient; and
12 (2) A parent, guardian, or person having legal custody
13 consents in writing to:
14 (A) Allow the qualifying patient's the medical use of
15 marijuana;
16 (B) Serve as the qualifying patient's primary
17 caregiver; and
18 (C) Control the acquisition of the marijuana, the

19 dosage, and the frequency of the medical use of
20 marijuana by the qualifying patient.

21 (c) The authorization for the medical use of marijuana in
22 this section shall not apply to:

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- 1 \ (1) The medical use of marijuana that endangers the health
2 or well-being of another person;
- 3 (2) The medical use of marijuana:
- 4 (A) In a school bus, public bus, or any moving
5 vehicle;
- 6 (B) In the workplace of one's employment;
- 7 (C) On any school grounds;
- 8 (D) At any public park, public beach, public
9 recreation center, recreation or youth center; or
- 10 (E) Other place open to the public;
- 11 and
- 12 (3) The use of marijuana by a qualifying patient, parent,
13 or primary caregiver for purposes other than medical
14 use permitted by this chapter.

15 **§329-C Registration requirements.** (a) Physicians who issue
16 written certification shall register the names, addresses,
17 patient identification numbers, and other identifying information
18 of the patients issued written certifications with the department

19 of public safety.

20 (b) Qualifying patients shall register with the department
21 of public safety. Such registration shall be effective until the
22 expiration of the certificate issued by the physician. Every
23 qualifying patient shall provide sufficient identifying

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1 information to establish personal identity of the qualifying
2 patient and the primary caregiver. Qualifying patients shall
3 report changes in information within five working days. Every
4 qualifying patient shall have only one primary caregiver at any
5 given time. The department shall then issue to the qualifying
6 patient a registration certificate, and may charge a reasonable
7 fee not to exceed \$25.

8 (c) Primary caregivers shall register with the department
9 of public safety. Every primary caregiver shall be responsible
10 for the care of only one qualifying patient at any given time.

11 (d) Upon an inquiry by a law enforcement agency, the
12 department of public safety shall verify whether the particular
13 qualifying patient has registered with the department and may
14 provide reasonable access to the registry information for
15 official law enforcement purposes.

16 **§329-D Insurance not applicable.** This part shall not be
17 construed to require insurance coverage for the medical use of

18 marijuana.

19 §329-E Protections afforded to a qualifying patient or
20 primary caregiver. (a) A qualifying patient or the primary
21 caregiver may assert the medical use of marijuana as an
22 affirmative defense to any prosecution involving marijuana under
23 this chapter or chapter 712; provided that the qualifying patient

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	H.D. 1

1 or the primary caregiver strictly complied with the requirements
2 of this part.

3 (b) Any qualifying patient or primary caregiver not
4 complying with the permitted scope of the medical use of
5 marijuana shall not be afforded the protections against searches
6 and seizures pertaining to the misapplication of the medical use
7 of marijuana.

8 (c) No person shall be subject to arrest or prosecution for
9 simply being in the presence or vicinity of the medical use of
10 marijuana as permitted under this part.

11 §329-F Protections afforded to a treating physician. No
12 physician shall be subject to arrest or prosecution, penalized in
13 any manner, or denied any right or privilege for providing
14 written certification for the medical use of marijuana for a
15 qualifying patient; provided that:

16 (1) The physician has diagnosed the patient as having a
17 debilitating medical condition, as defined in section

18 329-A;
19 (2) The physician has explained the potential risks and
20 benefits of the medical use of marijuana, as required
21 under section 329-B;
22 (3) The written certification is based upon the physician's
23 professional opinion after having completed a full

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1 assessment of the patient's medical history and current
2 medical condition made in the course of a bona fide
3 physician-patient relationship; and
4 (4) The physician has complied with the registration
5 requirements of section 329-C.

6 §329-G Protection of marijuana and other seized property.
7 Marijuana, paraphernalia, or other property seized from a
8 qualifying patient or primary caregiver in connection with a
9 claimed medical use of marijuana under this part shall be
10 returned immediately upon the determination by a court that the
11 qualifying patient or primary caregiver is entitled to the
12 protections of this part, as evidenced by a decision not to
13 prosecute, dismissal of charges, or an acquittal; provided that
14 law enforcement agencies seizing live plants as evidence shall
15 not be responsible for the care and maintenance of such plants.

16 §329-H Fraudulent misrepresentation; penalty. (a)

17 Notwithstanding any law to the contrary, fraudulent
18 misrepresentation to a law enforcement official of any fact or
19 circumstance relating to the medical use of marijuana to avoid
20 arrest or prosecution under this part or chapter 712 shall be a
21 petty misdemeanor and subject to a fine of \$500.

22 (b) Notwithstanding any law to the contrary, fraudulent
23 misrepresentation to a law enforcement official of any fact or

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1 circumstance relating to the issuance of a written certificate by
2 a physician not covered under section 329-F for the medical use
3 of marijuana shall be a misdemeanor. This penalty shall be in
4 addition to any other penalties that may apply for the non-
5 medical use of marijuana. Nothing in this section is intended to
6 preclude the conviction of any person under section 710-1060 or
7 for any other offense under part V of chapter 710.

8 SECTION 3. Section 453-8, Hawaii Revised Statutes, is
9 amended by amending subsection (a) to read as follows:

10 "(a) In addition to any other actions authorized by law,
11 any license to practice medicine and surgery may be revoked,
12 limited, or suspended by the board at any time in a proceeding
13 before the board, or may be denied, for any cause authorized by
14 law, including but not limited to the following:

15 (1) Procuring, or aiding or abetting in procuring, a
16 criminal abortion;

- 17 (2) Employing any person to solicit patients for one's
18 self;
19 (3) Engaging in false, fraudulent, or deceptive
20 advertising, including[,] but not limited to:
21 (A) Making excessive claims of expertise in one or
22 more medical specialty fields;

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- 1 (B) Assuring a permanent cure for an incurable
2 disease; or
3 (C) Making any untruthful and improbable statement in
4 advertising one's medical or surgical practice or
5 business;
6 (4) Being habituated to the excessive use of drugs or
7 alcohol; or being addicted to, dependent on, or a
8 habitual user of a narcotic, barbiturate, amphetamine,
9 hallucinogen, or other drug having similar effects;
10 (5) Practicing medicine while the ability to practice is
11 impaired by alcohol, drugs, physical disability, or
12 mental instability;
13 (6) Procuring a license through fraud, misrepresentation,
14 or deceit, or knowingly permitting an unlicensed person
15 to perform activities requiring a license;

- 16 (7) Professional misconduct, hazardous negligence causing
- 17 bodily injury to another, or manifest incapacity in the
- 18 practice of medicine or surgery;
- 19 (8) Incompetence or multiple instances of negligence,
- 20 including[,] but not limited to[,] the consistent use
- 21 of medical service which is inappropriate or
- 22 unnecessary;

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- 1 (9) Conduct or practice contrary to recognized standards of
- 2 ethics of the medical profession as adopted by the
- 3 Hawaii Medical Association or the American Medical
- 4 Association;
- 5 (10) Violation of the conditions or limitations upon which a
- 6 limited or temporary license is issued;
- 7 (11) Revocation, suspension, or other disciplinary action by
- 8 another state or federal agency of a license,
- 9 certificate, or medical privilege for reasons as
- 10 provided in this section;
- 11 (12) Conviction, whether by nolo contendere or otherwise, of
- 12 a penal offense substantially related to the
- 13 qualifications, functions, or duties of a physician,
- 14 notwithstanding any statutory provision to the
- 15 contrary;

- 16 (13) Violation of chapter 329, the uniform controlled
- 17 substances act, or any rule adopted thereunder[;]
- 18 except as provided in section 329-B;
- 19 (14) Failure to report to the board, in writing, any
- 20 disciplinary decision issued against the licensee or
- 21 the applicant in another jurisdiction within thirty
- 22 days after the disciplinary decision is issued; or

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- 1 (15) Submitting to or filing with the board any notice,
- 2 statement, or other document required under this
- 3 chapter, which is false or untrue or contains any
- 4 material misstatement or omission of fact."

5 SECTION 4. Section 712-1240.1, Hawaii Revised Statutes, is
6 amended to read as follows:

7 "§712-1240.1 Defense to promoting. (1) It is a defense to
8 prosecution for any offense defined in this part that the person
9 who possessed or distributed the dangerous, harmful, or
10 detrimental drug did so under authority of law as a practitioner,
11 as an ultimate user of the drug pursuant to a lawful
12 prescription, or as a person otherwise authorized by law.

13 (2) It is an affirmative defense to prosecution for any
14 marijuana-related offense defined in this part that the person

15 who possessed or distributed the marijuana was authorized to
16 possess or distribute the marijuana for medical purposes pursuant
17 to part of chapter 329."

18 SECTION 5. This Act shall not affect rights and duties that
19 matured, penalties that were incurred, and proceedings that were
20 begun, before its effective date.

21 SECTION 6. If any provision of this Act, or the application
22 thereof to any person or circumstance is held invalid, the
23 invalidity does not affect other provisions or applications of

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1 the Act which can be given effect without the invalid provision
2 or application, and to this end the provisions of this Act are
3 severable.

4 SECTION 7. In codifying the new sections added by section
5 2, and referred to in sections 3 and 4 of this Act, the revisor
6 of statutes shall substitute the appropriate section numbers for
7 the letters used in designating the new sections of this Act.

8 SECTION 8. Statutory material to be repealed is bracketed.
9 New statutory material is underscored.

10 SECTION 9. This Act shall take effect upon its approval.

APPENDIX B

DEPARTMENT OF PUBLIC SAFETY

Adoption of Chapter 23-202
Hawaii Administrative Rules

December 14, 2000

SUMMARY

Chapter 23-202, Hawaii Administrative Rules,
entitled "Medical Use of Marijuana" is adopted.

HAWAII ADMINISTRATIVE RULES

TITLE 23

DEPARTMENT OF PUBLIC SAFETY

SUBTITLE 3

LAW ENFORCEMENT

CHAPTER 202

MEDICAL USE OF MARIJUANA

§23-202-1	Purpose
§23-202-2	Definitions
§23-202-3	Medical use of marijuana and conditions of use
§23-202-4	Registration requirements
§23-202-5	Fees for registration and re-registration
§23-202-6	Time and method of registration
§23-202-7	Modification, transfer, and termination of certificate
§23-202-8	Written certification/registry identification forms and verification
523-202-g	Registry identification certificate
§23-202-10	Confidentiality of information and records
§23-202-11	Monitoring and investigations
§23-202-12	Revocation of registry identification certificate
§23-202-13	Permissible amounts of medical marijuana
§23-202-14	Offenses and penalties
523-202-15	Severability

§23-202-1 Purpose. The purpose of this chapter is to set forth rules for the medical use, the registration of qualifying patients, and procedures for the implementation of Act 228, SLH 2000, Medical Use of Marijuana as specified in chapter 329, part IX, Hawaii Revised Statutes. The intent is not to legalize

§23-202-1

marijuana for other than medical purposes, nor to diminish public policy and laws against illegal drug use. [Eff. **DEC 28 2000**] (Auth: HRS §§329-31, 353C-2) (Imp: HRS §353C-2, SLH 2000, Act 228)

§23-202-2 Definitions. The following definitions shall apply in the interpretation and enforcement of this chapter:

"Adequate supply" means an amount of marijuana jointly possessed between the qualifying patient and the primary caregiver that is not more than is reasonably necessary to assure the uninterrupted availability of marijuana for the purpose of alleviating the symptoms or effects of a qualifying patient's debilitating medical condition; provided that the "adequate supply" jointly possessed by the qualifying patient and the primary caregiver not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

"Administrator" means the administrator of the narcotics enforcement division, department of public safety.

"Debilitating medical condition" means:

- (1) Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, or the treatment of these conditions;
- (2) A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:
 - (A) Cachexia or wasting syndrome;
 - (B) Severe pain;
 - (C) Severe nausea;
 - (D) Seizures, including those characteristic of epilepsy; or
 - (E) Severe and persistent muscle spasms, including those characteristic of multiple sclerosis or **Crohn's** disease;

or
- (3) Any **other** medical condition approved by the department of health pursuant to administrative rules in response to a request

from a physician or potentially qualifying patient.

"Department" means the department of public safety.

-Immature marijuana **plant**" means a marijuana plant, whether male or female, that has not yet flowered and which does not yet have buds that are readily observed by unaided visual examination.

"Marijuana"* shall have the same meaning as "marijuana" and "marijuana concentrate" as provided in sections 329-1 and 712-1240, Hawaii Revised Statutes.

"Mature plant" means a marijuana plant, whether male or female, that has flowered and which has buds that are readily observed by unaided visual examination.

"Medical use" means the acquisition, possession, cultivation, use, distribution, or transportation of marijuana or paraphernalia relating to the administration of marijuana to alleviate the symptoms or effects of a qualifying patient's debilitating medical condition. For the purposes of "medical use", the term distribution is limited to the transfer of marijuana and paraphernalia from the primary caregiver to the qualifying patient.

"Patient identification number" means with respect to the qualifying patient and primary caregiver:

- (1) The unique, valid Hawaii driver's license number of the qualifying patient, primary caregiver, Hawaii State identification number, or passport number;
- (2) If the **qualifying** patient or primary caregiver does not have a Hawaii driver's license or Hawaii State Identification number, the "patient identification number" means the patient's social security *number*; and
- (3) If the qualifying patient is less than eighteen years old and has no Hawaii driver's license, Hawaii State identification number, passport number or social security number, then the patient identification number means the unique number contained on the valid driver's license of the patient's parent or legal guardian.

"Physician" means a person who is licensed under chapters 453 and 460, Hawaii Revised Statutes, and is licensed with authority to prescribe drugs and is registered under section 329-32, Hawaii Revised Statutes. "Physician" does not include physician's assistant as described in section 453-5.3, Hawaii Revised Statutes.

"Primary caregiver" means a person, other than the qualifying patient and the qualifying patient's physician, who is eighteen years of age or older, and who has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana. In the case of a minor or an adult lacking legal capacity, the primary caregiver shall be a parent, guardian, or person having legal custody.

"Registry identification certificate" means a document issued by the department that identifies a patient authorized to engage in the medical use of marijuana, the patient's physician, the patient's designated primary caregiver, if any, and the location of the authorized marijuana plants.

"Qualifying patient" means a person who has been diagnosed by a physician as having a debilitating medical condition.

"Usable marijuana" means the dried leaves and flowers of the plant Cannabis family Moraceae, and any mixture of preparations thereof, that is appropriate for the medical use of marijuana. "Usable marijuana" does not include the seeds, stalks, and roots of the plant.

"Written certification" means the qualifying patient's medical records or a statement signed by a qualifying patient's physician, stating that in the physician's professional opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient. "Written certifications" are valid for only one year from the time of signing.

[Eff: **DEC 28 2000**] (Auth: HRS §§329-31, 353C-2)
(Imp: HRS §§329-121, 353C-2)

§23-202-3 Medical use of marijuana and conditions of use. (a) Notwithstanding any law to the contrary, the medical use of marijuana by a qualifying patient shall be permitted only if:

- (1) The qualifying patient has been diagnosed by a physician as having a debilitating medical condition;
- (2) The qualifying patient's physician has certified in writing that, in the physician's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient; and
- (3) The amount of marijuana does not exceed an adequate supply.

(b) Subsection (a) shall not apply to a qualifying patient under the age of eighteen years, unless:

- (1) The qualifying patient's physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient and to a parent, guardian, or person having legal custody of the qualifying patient; and
- (2) A parent, guardian, or person having legal custody consents in writing to:
 - (A) Allow the qualifying patient's medical use of marijuana;
 - (B) Serve as the qualifying patient's primary caregiver; and
 - (C) Control the acquisition of the marijuana, the dosage, and the frequency of the medical use of marijuana by the qualifying patient.

(c) The authorization for the medical use of marijuana in this section shall not apply to:

- (1) The medical use of marijuana that endangers the health or well-being of another person;
- (2) The medical use of marijuana:
 - (A) In a school bus, public bus, or any moving vehicle;
 - (B) In the workplace of one's employment;
 - (C) On any school grounds;
 - (D) At any public park, public beach, public

- recreation center, recreation or youth center; or
- (E) Any other place generally accessible to the public;
- (3) Any sale of marijuana; or
- (4) The use of marijuana by a qualifying patient, parent, or primary caregiver for purposes other than medical use permitted by this chapter. [Eff. DEC 28 2000] (Auth: HRS §§329-31, 353C-2) (Imp: HRS §§329-122, 353C-2)

§23-202-4 Registration requirements. (a)

Physicians who issue written certification shall register the names, addresses, patient identification numbers, and other identifying information of the qualifying patients issued written certifications with the department using the written certification/registry identification forms designated in section 23-202-8.

(b) Qualifying patients shall register with the department using the written certification/registry identification forms designated in section 23-202-8. Such registration shall be effective until the expiration of the certificate issued by the physician. Every qualifying patient shall provide sufficient identifying information to establish the identity of the qualifying patient and the primary caregiver. Upon verification of the information provided, the department shall issue to the qualifying patient a registry identification certificate.

(c) Primary caregivers shall register with the department using the written certification/registry identification forms designated in section 23-202-8. Every primary caregiver shall be responsible for the care of only one qualifying patient at any given time.

(d) Qualifying patients and primary caregivers shall report any change in information required by the department within five working days. A qualifying patient shall have only one primary caregiver and only one physician issuing a written certificate at any given time.

(e) Upon an inquiry by a law enforcement agency, the department of public safety shall verify that a patient is a lawful possessor of a registry

identification certificate, that a person is the designated primary caregiver of such a patient, that a person has submitted an application for a registry identification certificate that is pending verification by the department, that the persons registry identification certificate was denied but the denial is being appealed or to supply optional information provided on the written certification/registry identification forms, or as provided in section 23-202-11. [Eff **DEC 28 2000**] (Auth: HRS §§329-31, 353C-2) (Imp: HRS §§329-123, 353C-2)

§23-202-5 Fees for registration and re-registration. (a) For each registration or re-registration of a qualifying patient to utilize marijuana for medical use, the qualifying patient shall pay a registration fee of \$25 for an annual registration.

(b) For each duplicate registration requested, the registrant shall submit a written request and shall pay a fee of \$10. [Eff **DEC 28 2000**] (Auth: HRS §§329-31, 353C-2) (Imp: HRS §§329-123, 353C-2)

§23-202-6 Time and method of registration. (a) Registration fees shall be paid at the time the written certification/registry identification forms are submitted to the department. Payment shall be made in the form of a personal, certified, or cashier's check or money order made payable to the narcotics enforcement division, department of public safety. Payment made in the form of stamps, foreign currency, or third party endorsed checks will not be accepted. No refund will be issued once the written certification/registry identification forms has been received at the department.

(b) No person shall engage in the use of marijuana for medical purposes, until the completed written certification/registry identification forms and registration fees are submitted to the Department by the qualifying patient's physician. Upon receipt of the written certification/registry identification forms and registration fees, the department shall issue

a receipt, which shall serve as a temporary registration certificate. The temporary registration certificate shall be valid for not more than 60 days from the date of issuance or until the department issues or denies the registry identification certificate. In the absence of a natural disaster, state emergency, or union strike which would prevent the department from reviewing the written certification/registry identification forms, any registration pending more than sixty days after receipt of the completed written certification/registry identification forms shall be deemed granted.

(c) Each certificate shall expire annually as noted on the certificate. Qualifying patients and their primary caregivers may apply for renewal not earlier than sixty days prior to the expiration date of their certificate.

(d) Failure to obtain a certificate from the department will prohibit the applicant from engaging in any activity utilizing the medical use of marijuana as designated in section 329-122, Hawaii Revised Statutes.

(e) The administrator may require an applicant to submit such documents or written statements of fact relevant to the registration, as the administrator deems necessary to verify information on the written certification/registry identification forms. The failure of the applicant to provide the documents or statements within thirty days after being mailed a request to do so shall be deemed to be a waiver by the applicant of an opportunity to present the documents or facts for consideration by the administrator in processing the registration.

(f) The termination of a certificate shall occur:

- (1) Upon its expiration date;
- (2) For failure to pay the applicable registration or re-registration fees; or
- (3) For payment with a check that is dishonored upon first deposit that shall cause the certificate to be void ab initio.

[Eff: **DEC 28 2000**] (Auth: HRS §§329-31, 353C-2) (Imp: HRS §§329-123, 353C-2)

523-202-7 Modification, transfer, and termination of certificate. (a) In the event of a change of name or address of the qualifying patient, primary caregiver, or the location where the qualifying patient will elect to grow the qualifying patient's medical marijuana, the qualifying patient shall submit a letter to the department of public safety, narcotics enforcement division, with the updated information. The notification shall be submitted to the department within five working days of the change. No fee shall be assessed for the modification of the certificate.

(b) Failure to report a change of any of the information mentioned in subsection (a) shall invalidate the certificate as of the date of the change plus five working days and shall require re-registration and the imposition of a \$10 late fee.

(c) No certificate issued to a qualifying patient shall be assigned or otherwise transferred to any other patient.

(d) A qualifying patient who possesses a registry identification certificate pursuant to this section who no longer suffers from a debilitating medical condition shall return the registry identification certificate to the department within seven calendar days of notification of the diagnosis. The qualifying patient's primary caregiver shall also return the issued registry identification certificate within the same period of time and the qualifying patient's medical marijuana supply disposed of in accordance with procedures set forth in section 23-200-20.

(e) The qualifying patient's attending physician shall notify the department that the qualifying patient's condition no longer warrants the use of marijuana for medical purposes. The physician shall notify the qualifying patient of the contact.

(f) A certificate issued to a qualifying patient or primary caregiver is void upon the qualifying patient's death or if the patient's primary physician revokes the qualifying patient's written certificate. The qualifying patient's family, legal guardian, or primary caregiver shall notify the department within seven calendar days of the qualifying patient's death or revocation of the written certificate by the primary physician. The certificate shall be returned to the

department and the qualifying patient's medical marijuana supply shall be disposed of in accordance with the procedures set forth in section 23-200-20.

[Eff **DEC 28 2000**] (Auth: HRS §§329-31, 353C-2)
(Imp: HRS §§329-123, 353C-2)

§23-202-8 Written certification/registry identification forms and verification. (a) The department shall create registry identification registration forms and physician written certification forms for the medical use of marijuana and issue them to requesting physicians. The written certification /registry identification forms shall be issued by the department and serve as the physician's written certification and the registration forms for the qualifying patient and any primary caregiver. Physicians shall submit the completed qualifying patient and primary caregiver written certification /registry identification forms which shall include the names, patient identification numbers, date of birth, addresses and other information required by the department. The written certification/registry identification forms shall serve as the physician's written certification that the qualifying patient has been diagnosed with a debilitating medical condition; and that the physician has certified that in the physician's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient.

(b) Except as provided in subsection (d), the department shall issue a registry identification certificate to any qualifying patient authorized by a physician to utilize marijuana for medical purposes, who pays a fee in the amount established by the department, and who provides to the department a completed registration form that has been verified and approved.

(c) Written certification/registry identification forms are deemed complete when the qualifying patient's physician supplies all of the following information:

- (1) Completed copy of the written certification /registry identification forms, and parent/legal guardian (if applicable) forms;
 - (2) The qualifying patient and the primary caregiver (if applicable) must provide a copy of photo identification (i.e., Hawaii driver's license, State of Hawaii identification card, or passport) with the written certification/registry identification forms; and
 - (3) Optional information may be added to registration forms at the discretion of the department if the information serves the best interest of the qualifying patient and assists agencies in the implementation of Act 228, SLH 2000, Medical Use of Marijuana.
- (d) The department shall issue a registry identification certificate to a patient who is under eighteen years of age if the patient submits the materials required under subsection (a), and one of the patient's parents or legal guardians signs and has notarized a written declaration that states:
- (1) The patient's attending physician has explained to the patient and to one of the patient's parents or legal guardians the possible risks and benefits of the medical use of marijuana;
 - (2) The parent or legal guardian consents to the use of marijuana by the patient for medical purposes;
 - (3) The parent or legal guardian agrees to serve as the patient's designated primary caregiver; and
 - (4) The parent or legal guardian agrees to control the acquisition of marijuana and the dosage and frequency of use by **the patient.**
- (e) The department shall verify information on all initial registration forms and written documentation.
- (1) The department shall contact each qualifying patient and primary caregiver (if appropriate) by phone or by mail to confirm that the information provided is accurate. In cases where the qualifying patient is less

than eighteen years old, the department also shall contact the parent or legal guardian to verify the information. In cases where proof of identify is uncertain, the department may require a face-to-face meeting with the qualifying patient or primary caregiver or the production of additional identification materials for verification purposes or both; and

- (2) The department shall verify that the attending physician is licensed to practice in the State under chapters 453 and 460, Hawaii Revised Statutes, and is currently registered under section 329-32, Hawaii Revised Statutes. The department shall also contact each attending physician by phone or by mail to confirm that the information provided is accurate.

(f) Upon annual renewal of a registration, the department shall verify all new information and may verify information that has not changed.

[Eff: **DEC 28 2000**] (Auth: HRS §§329-31, 353C-2)
(Imp: HRS §§329-123, 353C-2)

§23-202-9 Registry identification certificate.

(a) Once the department has verified the information in the completed written certification/registry form submitted pursuant to this section, including the designated registration fee, the department shall issue a serially numbered registry identification certificate. The registry identification certificate shall state:

- (1) The certificate holder's name, address, patient identification number, and date of birth;
- (2) The date of issuance and expiration date of the registry identification certificate;
- (3) The name, address, and date of birth of the patient's designated primary caregiver, if any;
- (4) The name, address, and telephone number of the qualifying patient's physician;

(5) The address where the marijuana will be grown; and

(6) Such other optional information as the department may specify.

(b) When the patient to whom the department has issued a registry identification certificate pursuant to this section has specified a designated primary caregiver, the department shall issue an identification certificate to the designated primary caregiver. The primary caregiver's registry identification certificate shall contain the information provided in subsection (a).

(c) The department may deny a registration for the following reasons:

(1) The applicant did not provide the information required pursuant to section 23-202-8, and following a mailing from the department requesting additional information to complete the registration, did not adequately respond within thirty days; or

(2) The department determines that the information provided was falsified.

(d) When the department determines that an applicant does not qualify for a registry identification certificate, the department shall send the applicant a denial letter within sixty days of receipt of the fully completed registration. The letter shall state the reason for denial.

(e) An applicant may, within thirty days after notification of denial of registration, request in writing an administrative hearing to contest the department's decision in conformity with chapter 91, Hawaii Revised Statutes. Only the patient or primary caregiver whose registration has been denied, or, in the case of a patient under the age of eighteen years of age whose registration has been denied, the patient's parent or legal guardian shall have standing to contest the department's action.

[Eff. DEC 28 2000] (Auth: HRS §§329-31, 353C-2)
(Imp: HRS §§329-123, 353C-2)

523-202-10 Confidentiality of information and records. (a) The department shall create and maintain

both paper and computer data files of the qualifying patients and primary caregivers to whom the department has issued registry identification certificates. The data files will include all information collected on the registration forms or equivalent information from other written documentation, the date of issue, and the expiration date. Except as provided in subsection (b), the maintained information shall be confidential and not subject to public disclosure.

(b) Names and other identifying information from the data file established pursuant to subsection (a) may be released to:

- (1) Authorized employees of the department as necessary to perform official duties of the department, including the production of any reports of aggregate (i.e., non-identifying) data or statistics; and
- (2) Authorized employees of state or local law enforcement agencies when they provide a specific name or address. Information will be supplied as necessary to verify that a patient is a lawful possessor of a registry identification certificate, that a person is the designated primary caregiver of such a patient that a person has submitted an application for a registry identification certificate that is pending verification by the department, that the persons registry identification certificate was denied but the denial is being appealed or to supply optional information provided on the registration forms, or as provided in section 23-202-11. [Eff: DEC 28 2000] (Auth: HRS §§329-31, 353C-2) (Imp: HRS §§329-123, 353C-2)

§23-202-11 Monitoring and investigations. (a) The department may, at any time, contact a qualifying patient, primary caregiver, or attending physician by phone, mail, or in person to verify the current accuracy of information provided to the registration system.

(b) Notwithstanding subsection (a), the department may, when it has reason to believe a violation of the conditions of registration exist, either conduct investigations to collect evidence of violations of Act 228, SLH 2000, Medical Use of Marijuana, or refer violation to the proper state or local authorities. Such violations include, but are not limited to the following:

- (1) A qualifying patient fails to notify the department of any change in the patient's name, address, attending physician, designated primary caregiver, or growing location of marijuana to be used for medical purposes;
 - (2) A qualifying patient or designated primary caregiver fails to return the registry identification certificate to the department within seven calendar days of notification of the diagnosis that the qualifying patient no longer has a debilitating medical condition; and
 - (3) A qualifying patient, designated primary caregiver, or attending physician falsifies information during the registration or registration renewal process.
- [Eff **DEC 28 2000** | (Auth: HRS §§329-31, 353C-2) (Imp: HRS §§329-123, 353C-2)

§23-202-12 Revocation of registry identification certificate. (a) In accordance with these rules, the department has the authority to revoke a registry identification certificate, with suspension of the registry identification certificate pending administrative hearing on the revocation. The department under one or more of the following conditions may revoke a registry identification certificate:

- (1) The applicant or physician has furnished false or fraudulent material information or omitted information in any of the written certification/registry forms submitted to the department under this chapter;

- (2) The written certificate issued to the qualifying patient was not based upon provisions set forth in section 329-126, Hawaii Revised Statutes;
- (3) Suspension or revocation of a physician's medical license or state controlled substance registration as designated under section 329-32, Hawaii Revised Statutes; or
- (4) For violations of section 23-202-3, 23-202-7, 23-202-13 or **23-202-14**.

(b) When the department proposes to revoke a registration certificate of a qualifying patient or a designated primary caregiver, the department shall send a notice of proposed revocation by mail to the patient's address currently listed in the data file and a copy to the qualifying patient's primary caregiver and physician.

(c) A qualifying patient or designated primary caregiver may contest the proposed revocation of registration by submitting a request in writing within thirty days of the revocation for an administrative hearing in conformity with chapter 91, Hawaii Revised Statutes. The request for hearing shall be addressed to: Narcotics Enforcement Division, Department of Public Safety, 711 Kapiolani Boulevard, Suite 1422, Honolulu, HI 96813.

(d) The department may reinstate a registration certificate without reapplication. [Ef **DEC 28 2000**]

(Auth: HRS §§329-31, 353C-2) (Imp: HRS §§329-123, 353C-2)

§23-202-13 Permissible amounts of medical marijuana. (a) A qualifying patient who possesses a registry identification certificate issued pursuant to section 329-123, Hawaii Revised Statutes, may engage in and a registered primary caregiver of the patient may assist in, the medical use of marijuana only as justified to mitigate the symptoms or effects of the qualifying patient's debilitating medical condition.

(b) The medical marijuana shall be grown only at the following locations:

- (1) The qualifying patient's home address; or

(2) The primary caregiver's home address or other location owned or controlled by the qualifying patient or the primary caregiver that is approved by the administrator and designated on the registry certificate issued by the department.

(c) The qualifying patient and primary caregiver jointly may not possess more than an "adequate supply" which shall not exceed a total of three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

(d) If any individuals described in subsection (a) possess, deliver, or produce marijuana in excess of the amounts allowed in subsection (c), such individuals are not exempted from the criminal laws of the State.

[Eff: **DEC 28 2000**] (Auth: HRS §§329-31, 353C-2)
(Imp: HRS §§329-121, 353C-2)

§23-202-14 Offenses and penalties. Every person violating any provision of this chapter shall be subject to the provisions set forth in section 329-128, Hawaii Revised Statutes. [Eff: **DEC 28 2000**] (Auth: HRS §§329-31, 353C-2) (Imp: HRS §329-128)

§23-202-15 'Severability. Should any section, paragraph, sentence, clause, phrase, or application of this chapter be declared unconstitutional or invalid for any reason, the remainder or any other application of this chapter shall not be affected thereby.

[Eff: **DEC 28 2000**] (Auth: §§329-31, 353C-2) (Imp: HRS §353C-2, SLH 2000, Act 228)

APPENDIX C

07/11/08

POSTAL PLUS

p.2

@001



STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
919 Ala Moana Blvd. 4th Floor
Honolulu, Hawaii 96719

DAVID F. FRESKELING
Deputy Director of
Administration

TOMMY HINSON
Deputy Director
Corrections

JAMES L. PROPOITNICK
Deputy Director
Law Enforcement

No. _____

July 7, 2008

Dear

On June 24, 2008, medical marijuana registration information, which is maintained by the Department of Public Safety pursuant to §329-123, Hawaii Revised Statutes, was mistakenly forwarded by email to a news reporter by one of our department employees. The employee believed he was sending a different document. The information sent included the names and addresses of medical marijuana prescription holders, the names of the prescribing doctors and the medical marijuana certificate numbers issued to each prescription holder. Your name and corresponding information was included in this list.

When this breach in confidentiality was discovered on June 27, 2008, immediate steps were taken by this Department to investigate, to ensure destruction of the disseminated information and to correct the situation. As far as we can determine, the confidential listing was received by only two people, the news reporter and his editor. They have, at our request, destroyed the information, not kept any copies and have taken further steps to assure that all information is erased from any computer database in which the information may have been stored.

Steps are also being taken internally within my department so that this does not happen again. Our information technology personnel have isolated the medical marijuana registry so that it cannot be mistakenly forwarded in the future. Further protocol is also being activated putting additional internal controls into place.

The end result of this incident is that we have confirmed as much as possible that none of the disseminated information remains in anyone's control other than at this department. We write to inform you of this confidentiality breach however, because of the sensitive nature of the information and so that you can take any precautions you deem appropriate to protect yourself against possible misuse of this information. Neither social security numbers nor dates of birth were included in the information shared.

The Department of Public Safety extends its sincere apology to you and assures you that all steps are being taken to protect against the recurrence of this regrettable incident.

Sincerely,

Clayton Frank
Director

Received Time Jul. 11. 11:16AM

APPENDIX D

EXECUTIVE CHAMBERS

HONOLULU

July 8, 2008

STATEMENT OF OBJECTIONS TO HOUSE BILL NO. 2675

Honorable Members
Twenty-Fourth Legislature
State of Hawaii

Pursuant to Section 16 of Article III of the Constitution of the State of Hawaii, I am returning herewith, without my approval, House Bill No. 2675, entitled "A Bill for an Act Relating to Medical Marijuana."

The purpose of this bill is to create a "medical marijuana task force" within the University of Hawaii for administrative purposes. This task force is required to study whether current law affords an adequate supply of medical marijuana, whether it is feasible to establish marijuana growing facilities on each island, and whether inter-island marijuana transport can be made possible for traveling patients. The task force is also required to examine other issues and obstacles that patients encounter as well as research other states' medical marijuana programs and laws.

This bill is objectionable because it is an exercise aimed at finding ways to circumvent federal law. The use of marijuana, even medical marijuana, is illegal under federal law. It is, therefore, inappropriate for the State to recommend ways to maintain or increase the supply of marijuana, to make recommendations regarding the development of marijuana growing facilities, or to seek ways to circumvent federal prohibitions regarding the transport of marijuana.

Moreover, requiring the task force to be administratively attached to the University of Hawaii is inappropriate. Mandating the University's involvement when there is a clear conflict between State and federal law has the potential to adversely affect funding for a number of programs and research projects that rely on federal grants. Requiring the College of Tropical Agriculture and Human Resources to administer the work of the task force is also inappropriate as the legal, medical, public health, public safety, and transportation issues surrounding medical marijuana are far outside the college's purview.

Additionally, the composition of the task force itself is questionable because three of the eleven task force members are from a single private organization, the Drug Policy Forum of Hawaii. Seven of the eleven members are prescribers, patients, or members of the Drug Policy Forum, and are all likely to favor the expansion of medical marijuana access and programming.

While I am sympathetic towards those who suffer debilitating illnesses and appreciate organizations and advocates who are representing their interests, the task force should also have at heart the interests of the community at large. There are a host of unintended consequences related to the proliferation of medical marijuana that this task force is not required to address. Since I firmly believe that considerations must be made to ensure that Hawaii's communities remain safe and drug free, I must question whether this task force is capable of balancing the interests of both the community and medical marijuana patients.

STATEMENT OF OBJECTIONS
HOUSE BILL NO. 2675
Page 3

Additionally, the federal Office of National Drug Policy notes that there are other prescription drugs approved by the Federal Drug Administration that are safe and medically deemed effective in helping those with AIDS, glaucoma, cancer, and other painful illnesses.

For the foregoing reasons, I am returning House Bill No. 2675 without my approval.

Respectfully,

A handwritten signature in black ink, appearing to read "Linda Lingle", written in a cursive style.

LINDA LINGLE
Governor of Hawaii

APPENDIX E

VETO

THE SENATE
TWENTY-FIFTH LEGISLATURE, 2009
STATE OF HAWAII

S.B. NO. 1058
S.D. 2
H.D. 2
C.D. 1

A BILL FOR AN ACT

VETO OVERRIDE

RELATING TO CONTROLLED SUBSTANCES.

ACT No. 29

Approved: [Signature]

Dated: July 15, 2009

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1

PART I

2

SECTION 1. (a) There is established a medical cannabis

3

task force that shall be placed within the department of public

4

safety for administrative purposes. The purpose of the medical

5

cannabis task force shall be to review issues relating to the

6

medical marijuana program. The director of public safety shall

7

be responsible for administering the work of the medical

8

cannabis task force. The medical cannabis task force shall:

9

(1) Examine current state statutes, state administrative

10

rules, and all county policies and procedures relating

11

to the medical marijuana program;

12

(2) Examine all issues and obstacles that qualifying

13

patients have encountered with the medical marijuana

14

program;

15

(3) Examine all issue and obstacles that state and county

16

law enforcement agencies have encountered with the

17

medical marijuana program;



1 (8) A physician who authorizes or recommends the use of
2 medical cannabis that is nominated from a list jointly
3 submitted by the senate president and speaker of the
4 house of representatives to be appointed by the
5 governor;

6 (9) A Hawaii-licensed physician who specializes in pain
7 control and has issued a medical cannabis
8 recommendation that is nominated from a list jointly
9 submitted by the senate president and speaker of the
10 house of representatives to be appointed by the
11 governor;

12 (10) The president of West Oahu Hope for a Cure Foundation
13 or the president's designee;

14 (11) The director of Americans for Safe Access - Honolulu
15 Chapter, or the director's designee;

16 (12) One registered caregiver to be appointed by the
17 governor; and

18 (13) One representative of the American Civil Liberties
19 Union.

20 (c) The members of the task force shall select a
21 chairperson from among its members, who, in conjunction with the
22 director of public safety, shall establish task force



1 regulated in Hawaii. The legislature further notes that several
2 countries, such as Australia, Belgium, Denmark, Estonia,
3 Finland, Italy, Japan, Spain, and Sweden have passed regulatory
4 laws on *Salvia divinorum* or its primary psychoactive
5 constituent, salvinorin A. In the United States, California,
6 Delaware, Florida, Illinois, Iowa, Kansas, Louisiana, Maine,
7 Michigan, Mississippi, Missouri, New Jersey, North Dakota, Ohio,
8 Oklahoma, Pennsylvania, South Carolina, Tennessee, and Virginia
9 regulate *Salvia divinorum*, with approaches ranging from
10 classification as a Schedule I controlled substance to placing
11 restrictions on its sale. The legislature finds that possible
12 regulation of *Salvia divinorum* and its primary psychoactive
13 constituent, salvinorin A, is worthy of formal examination by
14 the State.

15 SECTION 3. (a) There is established a *Salvia divinorum*
16 task force within the department of public safety for
17 administrative purposes. The purpose of the *Salvia divinorum*
18 task force shall be to review the effects of *Salvia divinorum*
19 and its primary psychoactive constituent, salvinorin A. The
20 director of public safety shall be responsible for administering
21 the work of the *salvia divinorum* task force. The *Salvia*
22 *divinorum* task force shall:



1 (6) The president of the Drug Policy Forum of Hawaii or
2 the president's designee.

3 (c) The members of the task force shall select a
4 chairperson from among its members, who, in conjunction with the
5 director of public safety, shall establish task force
6 procedures, including the meeting schedule, voting procedures,
7 and member duties.

8 The members of the task force shall serve without
9 compensation, but shall be reimbursed for necessary expenses,
10 including travel expenses, incurred in the performance of their
11 official duties.

12 (d) The director of public safety shall submit a report of
13 the *Salvia divinorum* task force's findings and recommendations,
14 including any proposed legislation or rules, to the legislature
15 no later than twenty days prior to the convening of the regular
16 session of 2010.

17 (e) The *Salvia divinorum* task force shall cease to exist
18 on June 30, 2010.

19 PART III

20 SECTION 4. This Act shall take effect upon its approval.



APPENDIX F

EXECUTIVE CHAMBERS

HONOLULU

July 6, 2009

STATEMENT OF OBJECTIONS TO SENATE BILL NO. 1058

Honorable Members
Twenty-Fifth Legislature
State of Hawaii

Pursuant to Section 16 of Article III of the Constitution of the State of Hawaii, I am returning herewith, without my approval, Senate Bill No. 1058, entitled "A Bill for an Act Relating to Controlled Substances."

This bill establishes the medical cannabis task force within the Department of Public Safety to review issues relating to the medical marijuana program and make recommendations for any proposed legislation and rules. This bill also establishes the Salvia divinorum task force within the Department of Public Safety to review issues regarding the effects, use, and sale of Salvia divinorum and its primary psychoactive constituent, salvinorin A, and make appropriate legislative recommendations regarding the possible regulation of Salvia divinorum and salvinorin A. The Director of Public Safety is required to submit reports for both task forces to the Legislature prior to the convening of the regular session of 2010.

This bill is objectionable because the proposed task forces are unnecessary and would redirect limited resources within the Department of Public Safety from their primary functions of corrections and operations of the Sheriff Division.

The medical cannabis task force is unnecessary because it would attempt to deal with issues raised by medical marijuana users that can only be addressed by circumventing federal law. The use of marijuana and the distribution of marijuana are still illegal under federal law. Until that law is changed, it is

STATEMENT OF OBJECTIONS
SENATE BILL NO. 1058
Page 2

inappropriate for the State of Hawaii to support the production, transportation, and distribution of marijuana. The task force will not be able to resolve these issues.

The Salvia divinorum task force is also unnecessary. The Narcotics Enforcement Division of the Department of Public Safety is already working with county police departments, the Alcohol and Drug Abuse Division of the Department of Health, and the federal Drug Enforcement Administration to closely monitor this substance and determine if it should be scheduled as a controlled substance. Under the provisions of section 329-11, Hawaii Revised Statutes, the Department of Public Safety has the duty to annually recommend to the Legislature the necessary scheduling of any controlled substances, and the Department has the authority to temporarily establish the emergency scheduling of any substance, if necessary, pending legislative action.

The provisions pertaining to the Salvia divinorum task force may also raise a possible objection under Section 14 of Article III of the State Constitution, which states in pertinent part, "Each law shall embrace but one subject, which shall be expressed in its title." Salvia divinorum is not a controlled substance under Hawaii law and the bill is not amending our controlled substances law to include it. Consequently, the provisions pertaining to the Salvia divinorum task force could possibly be challenged as being beyond the scope of the subject of this bill as expressed in its title.

STATEMENT OF OBJECTIONS
SENATE BILL NO. 1058
Page 3

For the foregoing reasons, I am returning Senate Bill
1058 without my approval.

Respectfully,



LINDA LINGLE
Governor of Hawaii

APPENDIX G

California to force HHS to change the four statements, which the organization believes are not science-based. The case is pending.

State and Local Referenda and Legislation

In the face of federal intransigence on the issue, advocates of medical marijuana have turned to the states in a largely successful effort, wherever it has been attempted, to enact laws that enable patients to obtain and use botanical marijuana therapeutically in a legal and regulated manner, even though such activity remains illegal under federal law.

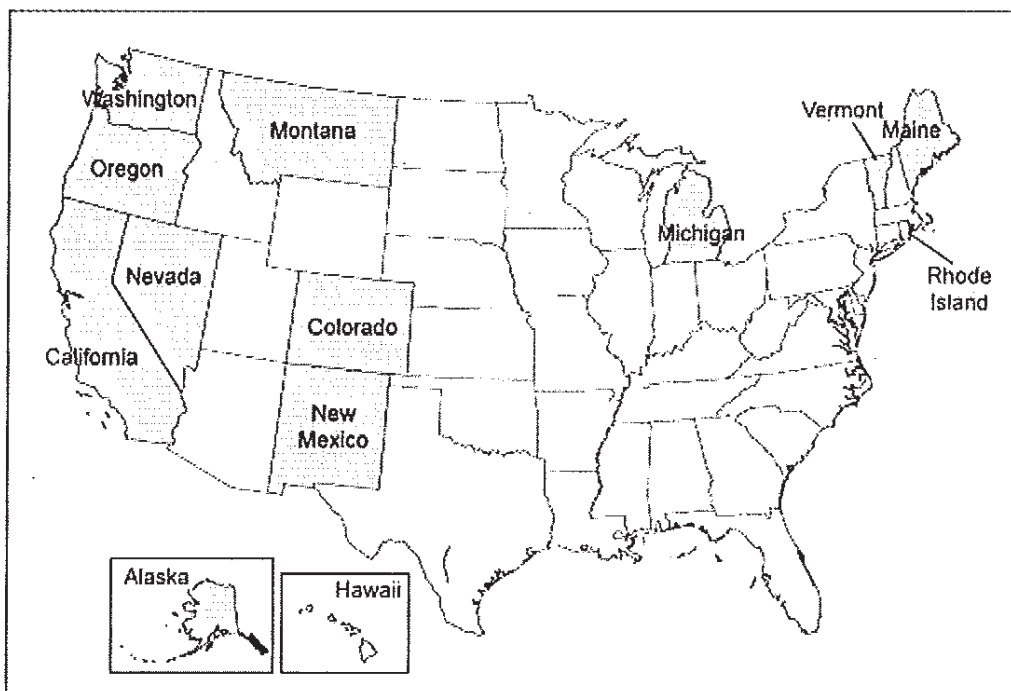
States Allowing Use of Medical Marijuana⁶⁵

Thirteen states, covering about 25% of the U.S. population, have enacted laws to allow the use of cannabis for medical purposes.⁶⁶ These states have removed state-level criminal penalties for the cultivation, possession, and use of medical marijuana, if such use has been recommended by a medical doctor. All of these states have in place, or are developing, programs to regulate the use of medical marijuana by approved patients. Patients in state programs (except for New Mexico) may be assisted by caregivers—persons who are authorized to help patients grow, acquire, and use the drug. Physicians in these states are immune from liability and prosecution for discussing or recommending medical cannabis to their patients in accordance with state law.

⁶⁵ The information in this and the following section is drawn largely from *State-by-State Medical Marijuana Laws: How to Remove the Threat of Arrest*, Marijuana Policy Project, July 2004, available at <http://www.mpp.org/statelaw/index.html>. More recent information is from press reports.

⁶⁶ Alaska (Stat. §11.71.090); California (Cal.Health & Safety Code Ann. §11362.5) and (2003 CA S.B. 420 (SN)); Colorado (Colo.Const. Art. XVIII §14); Hawaii (Rev.Stat. §§329-121 to 329-128); Maine (Me.Rev.Stat. Ann. tit.22 §1102 or 2382-B(5)); Montana (Mont.Code Ann. §§50-46-101 to 50-46-210); Nevada (Nev.Rev.Stat. Ann. §§453A.010 to 453A.400); New Mexico (S.B. 523); Oregon (Ore.Rev.Stat. §§475.300 to 475.346); Rhode Island (RI ST §§21-28.6-1); Vermont (Vt.Stat. Ann. tit. 18, §§4472-4474d); Washington (Wash.Rev.Code Ann. §§69.51A.005 to 69.51A.902).

Figure 1. States With Medical Marijuana Programs



Source: Map Resources. Adapted by CRS.

Nine of the 13 states that have legalized medical marijuana are in the West: Alaska, California, Colorado, Hawaii, Montana, Nevada, New Mexico, Oregon, and Washington. Of the 37 states outside the West, Michigan plus three other states, all in the Northeast—Maine, Rhode Island, and Vermont—have adopted medical cannabis statutes. Hawaii, New Mexico, Rhode Island, and Vermont have the only programs initiated by acts of their state legislatures. The medical marijuana programs in the other nine states were approved by the voters in statewide referenda or ballot initiatives, beginning in 1996 with California. Since then, voters have approved medical marijuana initiatives in every state where they have appeared on the ballot with the exception of South Dakota, where a medical marijuana initiative was defeated in 2006 by 52% of the voters. Bills to create medical marijuana programs have been introduced in the legislatures of additional states—Alabama, Connecticut, Illinois, Maryland, Minnesota, New Hampshire, New Jersey, among others—and have received varying levels of consideration but have so far not been enacted.

Effective state medical marijuana laws do not attempt to overturn or otherwise violate federal laws that prohibit doctors from writing prescriptions for marijuana and pharmacies from distributing it. In the 13 states with medical marijuana programs, doctors do not actually prescribe marijuana, and the marijuana products used by patients are not distributed through pharmacies. Rather, doctors *recommend* marijuana to their patients, and the cannabis products are grown by patients or their caregivers, or they are obtained from cooperatives or other alternative dispensaries. The state medical marijuana programs do, however, contravene the federal prohibition of marijuana. Medical marijuana patients, their caregivers, and other marijuana providers can, therefore, be arrested by federal law enforcement agents, and they can be prosecuted under federal law.

Statistics on Medical Marijuana Users

Determining exactly how many patients use medical marijuana with state approval is difficult. According to a 2002 study published in the *Journal of Cannabis Therapeutics*, an estimated 30,000 California patients and another 5,000 patients in eight other states possessed a physician's recommendations to use cannabis medically.⁶⁷ More recent estimates are much higher. The *New England Journal of Medicine* reported in August 2005, for example, that an estimated 115,000 people have obtained marijuana recommendations from doctors in the states with programs.⁶⁸

Although 115,000 people may be approved medical marijuana users, the number of patients who have actually registered is much lower. A July 2005 CRS telephone survey of the state programs revealed a total of 14,758 registered medical marijuana users in eight states.⁶⁹ (Maine and Washington do not maintain state registries, and Rhode Island, New Mexico, and Michigan had not yet passed their laws.) This number vastly understates the number of medical marijuana users, however, because California's state registry was in pilot status, with only 70 patients so far registered.

A brief description of each state's medical marijuana programs follows. The programs are discussed in the order in which they were approved by voters or passed by the state legislatures.

California (1996)

Proposition 215, approved by 56% of the voters in November, removed the state's criminal penalties for medical marijuana use, possession, and cultivation by patients with the "written or oral recommendation or approval of a physician" who has determined that the patient's "health would benefit from medical marijuana." Called the Compassionate Use Act, it legalized cannabis for "the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief." The law permits possession of an amount sufficient for the patient's "personal medical purposes." A second statute (Senate bill 420), passed in 2003, allows "reasonable compensation" for medical marijuana caregivers and says that distribution should be done on a nonprofit basis.

Oregon (1998)

Voters in November removed the state's criminal penalties for use, possession, and cultivation of marijuana by patients whose physicians advise that marijuana "may mitigate the symptoms or effects" of a debilitating condition. The law, approved by 55% of Oregon voters, does not provide for distribution of cannabis but allows up to seven plants per patient (changed to 24 plants by act of the state legislature in 2005). The state registry program is supported by patient fees. (In the November 2004 election, 58% of Oregon voters rejected a measure that would have expanded the state's existing program.)

⁶⁷ Dale Gieringer, "The Acceptance of Medical Marijuana in the U.S.," *Journal of Cannabis Therapeutics*, vol. 3, no. 1 (2003), pp. 53-67. The author later estimated that there were more than 100,000 medical marijuana patients in California alone (personal communication dated April 30, 2004).

⁶⁸ Susan Okie, "Medical Marijuana and the Supreme Court," *New England Journal of Medicine*, vol. 353, no. 7 (August 18, 2005), p. 649.

⁶⁹ The telephone survey was conducted for this report by CRS summer intern Brooks Andrew Meade.

Alaska (1998)

Voters in November approved a ballot measure to remove state-level criminal penalties for patients diagnosed by a physician as having a debilitating medical condition for which other approved medications were considered. The measure was approved by 58% of the voters. In 1999, the state legislature created a mandatory state registry for medical cannabis users and limited the amount a patient can legally possess to 1 ounce and six plants.

Washington (1998)

Approved in November by 59% of the voters, the ballot initiative exempts from prosecution patients who meet all qualifying criteria, possess no more marijuana than is necessary for their own personal medical use (but no more than a 60-day supply), and present valid documentation to investigating law enforcement officers. The state does not issue identification cards to patients.

Maine (1999)

Maine's ballot initiative, passed in November by 61% of the voters, puts the burden on the state to prove that a patient's medical use or possession is not authorized by statute. Patients with a qualifying condition, authenticated by a physician, who have been "advised" by the physician that they "might benefit" from medical cannabis, are permitted 1¼ ounces and six plants. There is no state registry of patients.

Hawaii (2000)

In June, the Hawaii legislature approved a bill removing state-level criminal penalties for medical cannabis use, possession, and cultivation of up to seven plants. A physician must certify that the patient has a debilitating condition for which "the potential benefits of the medical use of marijuana would likely outweigh the health risks." This was the first state law permitting medical cannabis use that was enacted by a legislature instead of by ballot initiative.

Colorado (2000)

A ballot initiative to amend the state constitution was approved by 54% of the voters in November. The amendment provides that lawful medical cannabis users must be diagnosed by a physician as having a debilitating condition and be "advised" by the physician that the patient "might benefit" from using the drug. A patient and the patient's caregiver may possess 2 usable ounces and six plants.

Nevada (2000)

To amend the state constitution by ballot initiative, a proposed amendment must be approved by the voters in two separate elections. In November, 65% of Nevada voters passed for the second time an amendment to exempt medical cannabis users from prosecution. Patients who have "written documentation" from their physicians that marijuana may alleviate their health condition may register with the state Department of Agriculture and receive an identification card that exempts them from state prosecution for using medical marijuana.

Vermont (2004)

In May, Vermont became the second state to legalize medical cannabis by legislative action instead of ballot initiative. Vermont patients are allowed to grow up to three marijuana plants in a locked room and to possess 2 ounces of manicured marijuana under the supervision of the Department of Public Safety, which maintains a patient registry. The law went into effect without the signature of the governor, who declined to sign it but also refused to veto it, despite pressure from Washington. A 2007 legislative act expanded eligibility for the program and increased to nine the number of plants participants may grow.

Montana (2004)

In November, 62% of state voters passed Initiative 148, allowing qualifying patients to use marijuana under medical supervision. Eligible medical conditions include cancer, glaucoma, HIV/AIDS, wasting syndrome, seizures, and severe or chronic pain. A doctor must certify that the patient has a debilitating medical condition and that the benefits of using marijuana would likely outweigh the risks. The patient may grow up to six plants and possess 1 ounce of dried marijuana. The state public health department registers patients and caregivers.

Rhode Island (2006)

In January, the state legislature overrode the governor's veto of a medical marijuana bill, allowing patients to possess up to 12 plants or 2½ ounces to treat cancer, HIV/AIDS, and other chronic ailments. The law included a sunset provision and was set to expire on July 1, 2007, unless renewed by the legislature. The law was made permanent on June 21, 2007, after legislators voted again to override the governor's veto by a wide margin.

New Mexico (2007)

Passed by the legislature and signed into law by the governor in April, the Lynn and Erin Compassionate Use Medical Marijuana Act went into effect on July 1, 2007. It requires the state's Department of Health to set rules governing the distribution of medical cannabis to state-authorized patients. Unlike other state programs, patients and their caregivers cannot grow their own marijuana; rather, it will be provided by state-licensed "cannabis production facilities."

Michigan (2008)

Approved by 63% of Michigan voters in the November 2008 presidential election, Proposal 1 permits physicians to approve marijuana use by registered patients with debilitating medical conditions, including cancer, HIV/AIDS, hepatitis C, multiple sclerosis, glaucoma, and other conditions approved by the state's Department of Community Health. Up to 12 plants can be cultivated in an indoor, locked facility by the patient or a designated caregiver.

Other State and Local Medical Marijuana Laws

Arizona (1996)

Arizona's law,⁷⁰ approved by 65% of the voters in November, permits marijuana prescriptions, but there is no active program in the state because federal law prohibits doctors from *prescribing* marijuana. Patients cannot, therefore, obtain a valid prescription. (Other states' laws allow doctors to "recommend" rather than "prescribe.")

Maryland (2003)

Maryland's General Assembly became the second state legislature, after Hawaii, to protect medical cannabis patients from the threat of jail when it approved a bill, later signed by the governor, providing that patients using marijuana preparations to treat the symptoms of illnesses such as cancer, AIDS, and Crohn's disease would be subject to no more than a \$100 fine.⁷¹ The law falls short of full legalization and does not create a medical marijuana program, but it allows for a medical necessity defense for people who use marijuana on their own for medical purposes. If patients arrested for possession in Maryland can prove in court that they use cannabis for legitimate medical needs, they escape the maximum penalty of one year in jail and a \$1,000 fine.

Other State Laws

Laws favorable to medical marijuana have been enacted in 36 states since 1978.⁷² Except for the state laws mentioned above, however, these laws do not currently protect medical marijuana users from state prosecution. Some laws, for example, allow patients to acquire and use cannabis through therapeutic research programs, although none of these programs has been operational since 1985, due in large part to federal opposition. Other state laws allow doctors to prescribe marijuana or allow patients to possess marijuana if it has been obtained through a prescription, but the federal Controlled Substances Act prevents these laws from being implemented. Several states have placed marijuana in a controlled drug schedule that recognizes its medical value. State legislatures continue to consider medical marijuana bills, some favorable to its use by patients, others not. In Michigan, a medical marijuana initiative will be presented to the voters on the November 2008 ballot.

District of Columbia (1998)

In the nation's capital, 69% of voters approved a medical cannabis initiative to allow patients a "sufficient quantity" of marijuana to treat illness and to permit nonprofit marijuana suppliers. Congress, however, has blocked the initiative from taking effect.⁷³

⁷⁰ Ariz.Rev.Stat. Ann. §13-3412.01(A).

⁷¹ Md. Crim.Code Ann. §5-601.

⁷² *State-by-State Medical Marijuana Laws: How to Remove the Threat of Arrest*, Marijuana Policy Project, July 2004, p. 3. The laws in some of these states have expired or been repealed.

⁷³ For more information on the situation in the District of Columbia, see CRS Report RL33563, *District of Columbia: Appropriations for 2007*, by Eugene Boyd and David P. Smole.

Local Measures

Medical cannabis measures have been adopted in several localities throughout the country. San Diego is the country's largest city to do so. One day after the Supreme Court's anti-marijuana ruling in *Gonzales v. Raich* was issued, Alameda County in California approved an ordinance to regulate medical marijuana dispensaries, becoming the 17th locality in the state to do so. Localities in nonmedical marijuana states have also acted. In November 2004, for example, voters in Columbia, MO, and Ann Arbor, MI, approved medical cannabis measures. Since then, four other Michigan cities, including Detroit, have done the same. Although largely symbolic, such local laws can influence the priorities of local law enforcement officers and prosecutors.

Public Opinion on Medical Marijuana

Voters in eight states have approved medical marijuana initiatives to protect patients from arrest under state law. Likewise, American public opinion has consistently favored access to medical marijuana by seriously ill patients. ProCon.org, a nonprofit and nonpartisan public education foundation, has identified 21 national public opinion polls that asked questions about medical marijuana from 1995 to the present. Respondents in every poll were in favor of medical marijuana by substantial margins, ranging from 60% to 85%.⁷⁴

The *Journal of the American Medical Association* analyzed public opinion on the War on Drugs in a 1998 article. The authors' observations concerning public attitudes toward medical marijuana remain true today:

While opposing the use or legalization of marijuana for recreational purposes, the public apparently does not want to deny very ill patients access to a potentially helpful drug therapy if prescribed by their physicians. The public's support of marijuana for medical purposes is conditioned by their belief that marijuana would be used only in the treatment of serious medical conditions.⁷⁵

In public opinion polls, then, the majority of Americans appear to hold that seriously ill or terminal patients should be able to use marijuana if recommended by their doctors. Thirteen state governments have created medical marijuana programs, either through ballot initiatives or the legislative process. Many other state governments, however, along with the federal government, remain opposed to the national majority in favor of medical marijuana.

⁷⁴ The questions asked and the results obtained can be viewed at <http://www.medicalmarijuanaprocon.org/pop/votesNat.htm>.

⁷⁵ Robert J. Blend on and John T. Young, "The Public and the War on Illicit Drugs," *Journal of the American Medical Association*, vol. 279, no. 11 (March 18, 1998), p. 831.

APPENDIX H

ACCESS, DISTRIBUTION, AND SECURITY COMPONENTS OF STATE MEDICAL MARIJUANA PROGRAMS

LANCE CHING
Research Attorney

Report No. 2, 2009

Legislative Reference Bureau
State Capitol
Honolulu, Hawaii 96813

<http://www.hawaii.gov/lrb>

FOREWORD

This report was undertaken in response to Act 29, First Special Session Laws of Hawaii 2009 (Senate Bill No. 1058, S.D. 2, H.D. 2, C.D. 1). The Bureau was requested to complete and submit to the Medical Cannabis Task Force "a report on the policies and procedures for access, distribution, security, and other relevant issues related to the medical use of cannabis for all the states that currently have a medical cannabis program."

During the 2000 Regular Session, the Hawaii Legislature enacted the Medical Use of Marijuana law, codified as Part IX of Chapter 329, Hawaii Revised Statutes. Essentially, the medical use of marijuana by qualifying individuals in Hawaii is permitted under certain conditions. However, the law does not provide these individuals with a legal method of obtaining medical marijuana. This study examines medical marijuana distribution systems that are operating or are currently being developed in other states.

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Chapter 2

HAWAII MEDICAL MARIJUANA PROGRAM

Hawaii was the first state to establish a medical marijuana program by legislation rather than by ballot initiative.¹ Hawaii's medical marijuana program was authorized by Act 228, Session Laws of Hawaii 2000. Act 228 became effective on June 14, 2000, and is codified as part IX, chapter 329, Hawaii Revised Statutes (HRS) (entitled "Medical Use of Marijuana"). The Department of Public Safety adopted administrative rules to implement the provisions of Act 228 on December 28, 2000.

What the Hawaii Medical Marijuana Program Does

Administered by the Department of Public Safety, the Hawaii Medical Marijuana program affords certain protections to qualifying patients, primary caregivers, and treating physicians. Specifically, section 329-125 provides that a qualifying patient or the primary caregiver of a qualifying patient may assert the medical use of marijuana as an affirmative defense to any prosecution involving marijuana, so long as the qualifying patient or primary caregiver has strictly complied with the requirements of the program. Similarly, section 329-126, HRS, provides that "[n]o physician shall be subject to arrest or prosecution, penalized in any manner, or denied any right or privilege for providing written certification for the medical use of marijuana for a qualifying patient[,]" so long as the physician strictly complies with the requirements of the program. The cumulative effect of these protections is the removal of state-level criminal penalties for the medical use of marijuana by qualifying patients.

Section 329-121, HRS, defines "medical use" as "the acquisition, possession, cultivation, use, distribution, or transportation of marijuana or paraphernalia relating to the administration of marijuana to alleviate the symptoms or effects of a qualifying patient's debilitating medical condition." A qualifying patient is generally allowed to select a primary caregiver, a person of at least eighteen years of age who agrees to undertake the responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana.² Section 329-121, HRS, also states that "[f]or the purposes of 'medical use', the term distribution is limited to the transfer of marijuana and paraphernalia from the primary caregiver to the qualifying patient."

Under section 329-122, HRS, the medical use of marijuana by a qualifying patient is permitted only so long as the amount of marijuana does not exceed an "adequate supply," which restricts the amount of marijuana jointly possessed between a qualifying patient and a primary caregiver to "not more than is reasonably necessary to assure the uninterrupted availability of marijuana for the purpose of alleviating the symptoms or effects of a qualifying patient's

¹ Alaska, California, Maine, Oregon, and Washington established medical marijuana programs by ballot initiative prior to the enactment of Act 228.

² In the case of a minor or an adult lacking legal capacity, the primary caregiver shall be a parent, guardian, or person having legal custody. Section 329-121, Hawaii Revised Statutes (HRS).

What the Hawaii Medical Marijuana Program Does Not Do

It should be noted that although the Hawaii medical marijuana program permits qualifying patients the use of medical marijuana, it does not provide patients with a method of obtaining marijuana. Qualifying patients cannot simply have a prescription for medical marijuana filled at a pharmacy. Under federal law, pharmacies are only permitted to dispense medications that have been prescribed. However, since marijuana is classified under federal law as a Schedule I controlled substance, physicians are not allowed to write prescriptions for its use. Under Hawaii law, a physician does not prescribe marijuana for medical purposes, but merely issues a written certification to a qualifying patient. The law is silent regarding how the qualifying patient is to obtain the marijuana.

While the medical marijuana program permits a qualifying patient and primary caregiver to grow marijuana plants for the patient's medical use, the state government does not provide a source or supply marijuana seeds or plants. Neither does it offer guidance on the cultivation of marijuana. Further, the sale of marijuana in any amount is strictly prohibited under state law.⁷ As a result, there is no place within the State where a person, even a qualifying patient with a valid registry identification certificate, can legally purchase marijuana.

After careful review of Hawaii's medical marijuana program, as codified under part IX of chapter 329, the Uniform Controlled Substances Act, and administered under chapter 23-202, Hawaii Administrative Rules, it appears that current state law is essentially silent with regard to issues of access, distribution, and security related to the medical use of marijuana.

⁷ Section 712-1247, HRS.

Table 3-1

**ACTIVE MEDICAL MARIJUANA PROGRAMS:
MAJOR POLICY COMPONENTS**

State	Removes State-Level Criminal Penalties?	Establishes Patient Registry and Issues ID Cards?	Maximum Marijuana Amount Allowed	Methods of Access and Distribution Specified
Alaska	Yes	Yes	1 ounce, 6 plants (up to 3 mature plants)	None
California	Yes	Yes ³	8 ounces, 6 mature plants (or 12 immature plants)	Cooperatives and Collectives
Colorado	Yes	Yes	2 ounces, 6 plants (up to 3 mature plants)	None
Hawaii	Yes	Yes	3 ounces, 3 mature plants, 4 immature plants	None
Maine	Yes	No	2.5 ounces, 6 plants (up to 3 mature plants)	None
Michigan	Yes	Yes	2.5 ounces, 12 plants	None
Montana	Yes	Yes	1 ounce, 6 plants	None
Nevada	Yes	Yes	1 ounce, 3 mature plants, 4 immature plants	None
New Mexico	Yes	Yes	6 ounces, 4 mature plants, 12 seedlings	State-licensed Producers
Oregon	Yes	Yes	24 ounces, 6 mature plants, 18 seedlings	None

³The California medical marijuana program directs the State Department of Health Services to establish a voluntary patient registry and to issue identification cards to qualifying patients who join the registry. Until recently, several counties had resisted implementing an identification card program by engaging in civil suits, arguing that the provisions of the California medical marijuana program were preempted by the federal Controlled Substances Act and violative of the state constitution. In *County of San Diego v. San Diego NORML*, 165 Cal.App.4th 798, 81 Cal.Rptr.3d 461 (Cal.App. 4 Dist., 2008), *cert denied*, 129 S.Ct. 2380 (2009), the Court of Appeal of the Fourth District of California held that the provisions of the California medical marijuana program were not preempted by federal law, nor in violation of the state constitution. As of this writing, most counties have initiated programs to gather patient information and to issue identification cards to qualifying patients.

Chapter 4

STATES WITH OPERATIVE OR DEVELOPING DISTRIBUTION SYSTEMS

California Medical Marijuana Program

On November 5, 1996, voters in California approved Proposition 215, the Medical Use of Marijuana Initiative Statute, which led to the enactment of the Compassionate Use Act of 1996 in that state. The following summary of Proposition 215 was prepared by California's Attorney General:¹

- Exempts patients and defined caregivers who possess or cultivate marijuana for medical treatment recommended by a physician from criminal laws which otherwise prohibit possession or cultivation of marijuana.
- Provides physicians who recommend use of marijuana for medical treatment shall not be punished or denied any right or privilege.
- Declares that measure not be construed to supersede prohibitions of conduct endangering others or to condone diversion of marijuana for non-medical purposes.
- Contains severability clause.

The Compassionate Use Act was later amended by Senate Bill No. 420, also known as the Medical Marijuana Program Act, which was enacted in October 2003 and took effect on January 1, 2004. As stated in section 1(b), the legislative intent of the Medical Marijuana Program Act was to:

- (1) Clarify the scope of the application of the act and facilitate the prompt identification of qualified patients and their designated primary caregivers in order to avoid unnecessary arrest and prosecution of these individuals and provide needed guidance to law enforcement officers.
- (2) Promote uniform and consistent application of the act among the counties within the state.
- (3) Enhance the access of patients and caregivers to medical marijuana through collective, cooperative cultivation projects.

The provisions of the Compassionate Use Act and the Medical Marijuana Program Act are codified in sections 11362.5 - 11362.83 of the California Health and Safety Code. Like Hawaii, California's state law is essentially silent regarding qualifying patients' access to medical marijuana. Since marijuana is classified under federal law as a Schedule I controlled substance, patients in California are unable to obtain a prescription for marijuana. Also, like Hawaii, California does not provide qualifying patients with marijuana, seeds, or advice on how to obtain

¹ California, Attorney General. Summary of Medical Use of Marijuana Initiative Statute at <http://vote96.sos.ca.gov/Vote96/html/BP/215.htm>.

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.” 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. Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. 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.” Agricultural cooperatives share many characteristics with consumer cooperatives. Cooperatives should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members.

2. **Collectives:** California law does not define collectives, but the dictionary defines them 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 between members.⁴

While the Attorney General differentiates between cooperatives and collectives, they are essentially treated equally, so long as they are organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws.⁵ To ensure this, the Attorney General makes the following suggestions regarding the operation of a cooperative or collective:⁶

1. **Non-Profit Operation:** Nothing in Proposition 215 or the [Medical Marijuana Program Act (MMP)] authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana

2. **Business Licenses, Sales Tax, and Seller’s 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:

⁴ *Ibid.* (Citations omitted.)

⁵ *See Ibid.*

⁶ *See Ibid.*

- 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.

It should be noted that there is no statewide regulation of cooperatives and collectives. Rather, many cities and counties have issued ordinances to regulate the operation of medical marijuana dispensaries run by cooperatives and collectives within their respective jurisdictions. As a result, the range of regulatory requirements varies greatly between the various cities and counties.⁷ For example, Santa Clara County places zoning restrictions on where a dispensary may be located, prohibits the smoking, ingestion, or consumption of marijuana on the premises, specifies that patients under the age of 18 shall only be allowed to enter the premises when accompanied by a parent or guardian, and specifies the hours of operation.⁸ On the other hand, the City of Oakland also places zoning restrictions on where a dispensary may operate, but

⁷ As of this writing, Americans for Safe Access lists 32 cities and 8 counties in California that have issued ordinances to regulate medical marijuana dispensaries, 51 cities and 3 counties that have issued moratoriums on medical marijuana dispensaries, and 113 cities and 7 counties that have banned medical marijuana dispensaries. Available at www.safeaccessnow.org/article.php?id=3165.

⁸ Sections B26-3 and B26-4 of the County of Santa Clara Ordinance Code.

I. Signage for the establishment shall be limited to one wall sign not to exceed ten square feet in area, and one identifying sign not to exceed two square feet in area; such signs shall not be directly illuminated.

J. The dispensary shall provide City Manager or his/her designee, the chief of police and all neighbors located within fifty (50) feet of the establishment with the name, phone number and facsimile number of an on-site community relations staff person to whom one can provide notice if there are operating problems associated with the establishment. The dispensary shall make every good faith effort to encourage neighbors to call this person to try to solve operating problems, if any, before any calls or complaints are made to the police department or other city officials.

K. The dispensary shall meet any specific, additional operating procedures and measures as may be imposed as conditions of approval by the City Manager or his/her designee in order to insure that the operation of the dispensary is consistent with protection of the health, safety and welfare of the community, qualified patients and caregivers, and will not adversely affect surrounding uses.

New Mexico Medical Marijuana Program

The Lynn and Erin Compassionate Use Act was enacted on April 2, 2007, and took effect on July 1, 2007. The provisions of the Lynn and Erin Compassionate Use Act are codified in chapter 26, article 2B, New Mexico Statutes Annotated (NMSA). As stated in section 26-2B-2, NMSA, the purpose of the Lynn and Erin Compassionate Use Act is "to allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments."

New Mexico's medical marijuana program is similar to those in other states in that it removes state-level criminal penalties for the medical use of marijuana. However, the New Mexico program is unique in that it was the first program to establish a state-regulated system for the distribution of medical marijuana. Specifically, the New Mexico program allows medical marijuana to be dispensed by licensed producers. Section 26-2B-3, NMSA, defines the term "licensed producer" as "any person or association of persons within New Mexico that the department [of health] determines to be qualified to produce, possess, distribute and dispense cannabis pursuant to the Lynn and Erin Compassionate Use Act and that is licensed by the department [of health]." Section 26-2B-7, NMSA, directs the New Mexico Department of Health to promulgate rules to "identify requirements for the licensure of producers and cannabis production facilities and set forth procedures to obtain licenses;" and to "develop a distribution system for medical cannabis that provides for: (a) cannabis production facilities within New Mexico housed on secured grounds and operated by licensed producers; and (b) distribution of medical cannabis to qualified patients or their primary caregivers to take place at locations that are designated by the department and that are not within three hundred feet of any school, church or daycare center[.]" The New Mexico Department of Health finalized its rules in Title 7, Chapter 34, New Mexico Administrative Code (NMAC), entitled "Medical Use of Marijuana."

ACCESS, DISTRIBUTION, AND SECURITY COMPONENTS OF STATE MEDICAL MARIJUANA PROGRAMS

(11) a description of potential side effects and how this shall be communicated to qualified patients and the qualified patient's primary caregivers;

(12) a description of the private entity's means for educating the qualified patient and the primary caregiver on the limitation of the right to possess and use marijuana;

(13) a description of the packaging of the useable marijuana that the private non-profit entity shall be utilizing, including a label that shall contain the name of the strain, batch, quantity and a statement that the product is for medical use and not for resale;

(14) a description of the private non-profit entity's confidential sale records, ensuring that quantities purchased do not suggest re-distribution; both clients and the department shall have access to this information at any time;

(15) a description of the private non-profit entity's policy on the right of the entity to refuse service;

(16) a description of the device or series of devices that shall be used to provide security;

(17) a written description of the private non-profit entity's security policies, safety and security procedures, personal safety and crime prevention techniques;

(18) copies of the entity's articles of incorporation and by-laws;

(19) a list of all persons or business entities having direct or indirect authority over the management or policies of the facility;

(20) a list of all persons or business entities having five percent or more ownership in the facility, whether direct or indirect and whether the interest is in profits, land or building, including owners of any business entity which owns all or part of the land or building;

(21) the identities of all creditors holding a security interest in the premises, if any;

(22) criminal history screening requirements:

(a) all persons associated with a non-profit private entity production facility must consent to a nationwide and statewide criminal history screening background check; this includes board members, persons having direct or indirect authority over management or policies, and employees; all applicable fees associated with the nationwide and statewide criminal history screening background check shall be paid by the individual or production facility;

(b) individuals convicted of a felony violation of Section 30-31-20 [(trafficking controlled substances)], 30-31-21 [(Distribution to a minor)], or 30-31-22 [(Distribution of controlled or counterfeit substances)] NMSA 1978 are prohibited from participating or being associated with a production facility licensed under this rule; if an

ACCESS, DISTRIBUTION, AND SECURITY COMPONENTS OF STATE MEDICAL MARIJUANA PROGRAMS

(3) alcohol and drug free work place policy; the private non-profit entity shall develop, implement and maintain on the premises, policies and procedures relating to an alcohol and drug free workplace program;

(4) employee policies and procedures; the private non-profit entity shall develop, implement and maintain on the premises, employee policies and procedures to address the following requirements:

(a) a job description or employment contract developed for all employees, which includes duties, authority, responsibilities, qualifications and supervision; and

(b) training in, and adherence, to state confidentiality laws;

(5) the licensed producer shall maintain a personnel record for each employee that includes an application for employment and a record of any disciplinary action taken; and

(6) the private non-profit entity shall develop, implement and maintain on the premises on-site training curriculum, or enter into contractual relationships with outside resources capable of meeting employee training needs, which includes, but is not limited to, the following topics:

(a) professional conduct, ethics and patient confidentiality; and

(b) informational developments in the field of medical use of marijuana;

(7) employee safety and security training; the private non-profit entity shall provide each employee, at the time of his or her initial appointment, training in the following:

(a) the proper use of security measures and controls that have been adopted; and

(b) specific procedural instructions on how to respond to an emergency, including robbery or a violent accident.

(8) all private non-profit entities shall prepare training documentation for each employee and have employees sign a statement indicating the date, time and place the employee received said training and topics discussed, to include name and title of presenters; the private non-profit entity shall maintain documentation of an employee's training for a period of at least six (6) months after termination of an employee's employment; employee training documentation shall be made available within twenty-four (24) hours of a department representative's request; the twenty-four (24) hour period shall exclude holidays and weekends.

Rhode Island Medical Marijuana Program

The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act became effective on January 3, 2006. Like the medical marijuana programs of many other states, the Rhode Island program removed state-level criminal penalties for the use of marijuana for medical purposes, but did not provide a method for qualifying patients to obtain marijuana. However, this latter situation changed on June 16, 2009, when the Rhode Island General Assembly overrode vetoes of the Governor of Rhode Island. Chapters 16 and 17, 2009 Public Laws of Rhode Island and Providence Plantations amended Rhode Island's medical marijuana program by, among other things, calling for the establishment of up to three state-licensed "compassion centers." Compassion centers are defined in section 21-28.6-3, General Laws of Rhode Island (Gen. Laws), as non-profit entities that are licensed by the Rhode Island to acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana, or related supplies and educational materials, to registered qualifying patients and their registered primary caregivers. This makes Rhode Island the third state, including California and New Mexico, to allow the operation of dispensaries for medical marijuana.

Chapters 16 and 17 also amend the medical marijuana program by directing the Rhode Island Department of Health to promulgate regulations to govern the licensing and operation of the compassion centers.²⁴ The first license for the operation of a compassion center is expected to be granted within the next six months.

Although, as of this writing, the Rhode Island Department of Health has not yet promulgated regulations regarding the operation of compassion centers, Chapters 16 and 17, codified as part of Section 21-28.6-12, Gen. Laws, provides some insight into how a compassion center would be run. The law imposes the following operating requirements on compassion centers.

(1) A compassion center shall be operated on a not-for-profit basis for the mutual benefit of its patients. A compassion center need not be recognized as a tax-exempt organization by the Internal Revenue Services;

(2) A compassion center may not be located within five hundred feet (500') of the property line of a preexisting public or private school;

(3) A compassion center shall notify the department within ten (10) days of when a principal officer, board member, agent, volunteer or employee ceases to work at the compassion center. His or her card shall be deemed null and void and the person shall be liable for any other penalties that may apply to the person's nonmedical use of marijuana;

(4) A compassion center shall notify the department in writing of the name, address, and date of birth of any new principal officer, board member, agent, volunteer or

²⁴ The regulations promulgated by the Rhode Island Department of Health shall address the following areas: (1) the form and content of registration and renewal applications; (2) minimum oversight requirements for compassion centers; (3) minimum record-keeping requirements for compassion centers; (4) minimum security requirements for compassion centers; and (5) procedures for suspending or terminating the registration of compassion centers.

(ii) Specific procedural instructions on how to respond to an emergency, including robbery or violent accident;

(14) All compassion centers shall prepare training documentation for each employee and have employees sign a statement indicating the date, time, and place the employee received said training and topics discussed, to include name and title of presenters. The compassion center shall maintain documentation of an employee's and a volunteer's training for a period of at least six (6) months after termination of an employee's employment or the volunteer's volunteering.

It should be noted that the legislation amending Rhode Island's medical marijuana program was enacted only months after statements were made by the United States Attorney General on February 25, 2009, signaling a policy shift regarding medical marijuana dispensaries.²⁵ The Attorney General subsequently reaffirmed on March 18, 2009, that the United States Department of Justice would no longer target medical marijuana dispensaries that were operating in compliance with state law.²⁶ The Attorney General went on to state that federal agents would only target medical marijuana dispensaries that violated both state and federal law.

Recent Action in Other States

On June 24, 2009, the New Hampshire General Court passed legislation to allow the use of marijuana for medical purposes. Although vetoed by New Hampshire's governor, the proposed law included provisions for the establishment of compassion centers, similar to those in the Rhode Island legislation.²⁷ As of this writing, several other states, including Delaware, Illinois, Iowa, Pennsylvania, New Jersey, New York, and North Carolina, are also considering legislation to allow the use of marijuana for medical purposes.

²⁵ Drug Trafficking Investigation. C-SPAN, Washington, D.C. 29 Feb. 2009. Available at www.c-spanarchives.org/library/index.php?main_page=product_video_info&products_id=284320-1.

²⁶ Scott Glover and Josh Meyer, *U.S. Won't Prosecute Medical Pot Sales*, Los Angeles Times, Mar. 19, 2009, at A1.

²⁷ The legislation, House Bill 648, was vetoed by the Governor of New Hampshire on July 10, 2009. It remains to be seen whether the New Hampshire General Court will override that action.

A BILL FOR AN ACT

VETO OVERRIDE

RELATING TO CONTROLLED SUBSTANCES.

ACT No. 29

Approved: *[Signature]*

Dated: July 15, 2009

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 PART I

2 SECTION 1. (a) There is established a medical cannabis
3 task force that shall be placed within the department of public
4 safety for administrative purposes. The purpose of the medical
5 cannabis task force shall be to review issues relating to the
6 medical marijuana program. The director of public safety shall
7 be responsible for administering the work of the medical
8 cannabis task force. The medical cannabis task force shall:

- 9 (1) Examine current state statutes, state administrative
10 rules, and all county policies and procedures relating
11 to the medical marijuana program;
- 12 (2) Examine all issues and obstacles that qualifying
13 patients have encountered with the medical marijuana
14 program;
- 15 (3) Examine all issue and obstacles that state and county
16 law enforcement agencies have encountered with the
17 medical marijuana program;



- 1 (8) A physician who authorizes or recommends the use of
- 2 medical cannabis that is nominated from a list jointly
- 3 submitted by the senate president and speaker of the
- 4 house of representatives to be appointed by the
- 5 governor;
- 6 (9) A Hawaii-licensed physician who specializes in pain
- 7 control and has issued a medical cannabis
- 8 recommendation that is nominated from a list jointly
- 9 submitted by the senate president and speaker of the
- 10 house of representatives to be appointed by the
- 11 governor;
- 12 (10) The president of West Oahu Hope for a Cure Foundation
- 13 or the president's designee;
- 14 (11) The director of Americans for Safe Access - Honolulu
- 15 Chapter, or the director's designee;
- 16 (12) One registered caregiver to be appointed by the
- 17 governor; and
- 18 (13) One representative of the American Civil Liberties
- 19 Union.

20 (c) The members of the task force shall select a

21 chairperson from among its members, who, in conjunction with the

22 director of public safety, shall establish task force



1 regulated in Hawaii. The legislature further notes that several
2 countries, such as Australia, Belgium, Denmark, Estonia,
3 Finland, Italy, Japan, Spain, and Sweden have passed regulatory
4 laws on *Salvia divinorum* or its primary psychoactive
5 constituent, salvinorin A. In the United States, California,
6 Delaware, Florida, Illinois, Iowa, Kansas, Louisiana, Maine,
7 Michigan, Mississippi, Missouri, New Jersey, North Dakota, Ohio,
8 Oklahoma, Pennsylvania, South Carolina, Tennessee, and Virginia
9 regulate *Salvia divinorum*, with approaches ranging from
10 classification as a Schedule I controlled substance to placing
11 restrictions on its sale. The legislature finds that possible
12 regulation of *Salvia divinorum* and its primary psychoactive
13 constituent, salvinorin A, is worthy of formal examination by
14 the State.

15 SECTION 3. (a) There is established a *Salvia divinorum*
16 task force within the department of public safety for
17 administrative purposes. The purpose of the *Salvia divinorum*
18 task force shall be to review the effects of *Salvia divinorum*
19 and its primary psychoactive constituent, salvinorin A. The
20 director of public safety shall be responsible for administering
21 the work of the *salvia divinorum* task force. The *Salvia*
22 *divinorum* task force shall:



1 (6) The president of the Drug Policy Forum of Hawaii or
2 the president's designee.

3 (c) The members of the task force shall select a
4 chairperson from among its members, who, in conjunction with the
5 director of public safety, shall establish task force
6 procedures, including the meeting schedule, voting procedures,
7 and member duties.

8 The members of the task force shall serve without
9 compensation, but shall be reimbursed for necessary expenses,
10 including travel expenses, incurred in the performance of their
11 official duties.

12 (d) The director of public safety shall submit a report of
13 the *Salvia divinorum* task force's findings and recommendations,
14 including any proposed legislation or rules, to the legislature
15 no later than twenty days prior to the convening of the regular
16 session of 2010.

17 (e) The *Salvia divinorum* task force shall cease to exist
18 on June 30, 2010.

19 PART III

20 SECTION 4. This Act shall take effect upon its approval.



APPENDIX I

Hawaii Medical Cannabis Working Group
“Talk Story” Notes
October 27, 2009, 6:30 p.m.
Hawaii State Capitol, Room 329

Opening Comments were made by Senator Wil Espero at 6:30 p.m.

- Update on SB1058 which established a taskforce to study medical marijuana issues.
- Explanation of the current working group as legislative intent; and the work to be done by the working group.

Comments by Pam Lichty, Co-Chair

- Warning that there is media in the room, if you want privacy, move to a section out of camera range.
- Introduction of the working group members:
R.C. Anderson, Americans for Safe Access
Mike Glenn, caregiver
Dr. Gary Greenly
Laurie Temple, Co-Chair, ACLU
Marvin Merritt, patient
Lila Rattner substituting for Joe Rattner, West Oahu Hope for a Cure

Comments by Laurie Temple, Co-Chair

- Explanation of ground rules and introduction of the discussion.
- The original patient questionnaire had the wrong fax number; patients were encouraged to expand on the questionnaire and send in their recommendations.

Pam Lichty explained the new federal policy on medical marijuana which now says federal resources will not be used prosecuting medical marijuana patients who abide by both state and federal laws.

Patient Comments:

Terri H.:

- Her private information was released to the media by NED
- Believes that NED should not run the program, health care providers are afraid
- Providers need to be more educated
- More user-friendly policy for workers, “need a model for the workplace,” since cannabis can stay in the system for a long time, urine test does not test for acute user
- Discrimination against renters, how are patients who rent supposed to grow?
- Information should be private between employee and employer
- Caregivers are exposed, need more caregivers
- Increase number of plants; allow for different strains, forms, doseages

Sherrie A., retired military with PTSD:

- Hard to become patient
- Extremely hard time getting medication
- Being in the military forces her to be silent

- She is not a criminal
- Mistaken for a prostitute in Waikiki when buying medication

Brian M., Patients without Time and Democracy in Action:

- Wants to see distribution system using family farmers “Sustainable Family Farm Act”; Hawaii has the best environment to grow cannabis and we should use it to build family farms and the economy
- Medical cannabis can be an export crop for Hawaii to other medical cannabis states
- Wants to see a distribution center on each island
- It takes a long time to grow: 90 days to grow, then drying time
- Make sure that local law enforcement follow the rules and state law rather than federal law
- Reciprocity for people from other medical cannabis states, temporary license for visitors

Mark N., Big Island patient and caregiver:

- Increase to 25 plants, uses 5-10 grams per day with a vaporizer
- Points out that Irv Rosenfeld, a federal medical cannabis patient, receives 300 rolled cannabis joints every 25 days or equivalent to 22.5 ounces of cannabis grown by the University of Mississippi.
- Likes the Washington and Oregon limits
- Some counties in California allow up to 99 plants
- Need distribution system and reciprocity

Dale M.:

- Agrees with what everyone has said so far
- Growing is not easy, it is time consuming
- Hard to get good seeds
- Change amount that a patient can have
- We should be on the forefront of medical cannabis, not California
- Honolulu Star Bulletin has an article today on cannabis
- Too costly to buy on the streets
- Would like to see a distribution system and also allow people to grow their own if they choose to

Don E., Hemp Alliance, Hawaii Cannabis Patient Alliance:

- This is an issue of Hawaiian values, using core values approach would help solve the problem
- Hope to see a long range look
- Need to have more aloha spirit in this legislation
- Do things differently

Steve C.:

- Patient for 10 years in Oregon, believes it is a great program
- Dispensary is most effective, even with some of the bad parts
- Some doctors do not want to be involved
- The work group is on the right track
- Law enforcement should be separate from the program
- In Oregon, cops don't come until something illegal has happened

Carl:

- Represents Generation X
- Need dispensaries
- Money drives the movement, if government wants a cut, then pot smokers don't mind
- If there wasn't pressure from the law, more people would be involved in the program
- Growing is not easy, we need dispensaries

Tracy:

- Uses medical cannabis because of migraines, just wants something to help her feel better
- Cannot grow
- Governor can make money off cannabis
- Wishes to find more patient groups
- Since she is was formerly with the military, is concerned with privacy
- The program should issue cards, but with no information

Nathan:

- Patient from California, 5years
- Concerned that taxes from dispensaries would go into the general state budget
- Dispensaries pay 8.5% and thousands of dollars, will Hawaii tax and allocate monies properly

Kainoa:

- Religious user with THC ministries
- People's religious use should be respected like anyone attending any church
- Open conversation
- Federal policy should be the approach
- Many more people would be interested in cannabis if it were not a Schedule I drug

Patient A:

- President Obama issued new policy in writing
- Hawaii has 3 seasons to grow cannabis
- Wants to see dispensaries done in the right way, likes Lila's idea
- Concerned with the cost
- Should be able to address the deficit

Patient B:

- Glaucoma patient
- Upset by the cannabis stereotypes
- Would like to see more education

Robert B.

- Brought reports for the working group
- Should also address the hemp laws
- Hemp has the potential for many economic benefits: fabric for clothes, energy, etc.
- Taxing is good and money should go to education and UH Research

- Need better testing for strains and specific ailments

Jeanne Ohta, Executive Director, Drug Policy Forum of Hawaii

- In response to a comment, explained the Colorado situation; that although their law is similar to Hawaii, the caregiver limit (5 patients to a caregiver) was found to be invalid by a Colorado court. Until the state can show that there is a legitimate reason for the limit, there is no limit in Colorado on how many patients a caregiver can have.

Randy C.

- Had personal property taken by the DEA at the airport
- Read DEA statement: DEA welcomes the new policy by the DOJ, will still prosecute illegal activity.

Dr. Wang

- Suggest that patients work with organic farmers association so that patients who are compromised are not exposed to chemicals and pesticides
- Make sure that programs allow for low-income patients
- Need to educate more people of the dangers of using cannabis

Norm C.:

- Hope there are broader options instead of just a public option (referring to Lila's proposal), include private industry
- Suggests Harborside dispensary (California) as a model

Billy:

- Cannabis has been used traditionally by many cultures
- More people are becoming involved
- Concerned that there as not been change for so long
- Believes that it should be taxed

(Compiled from notes taken by Mark Fisher and Jeanne Ohta)

APPENDIX J

HAWAII MEDICAL CANNABIS WORKING GROUP QUESTIONNAIRE

10/09

All responses are purely voluntary and for confidential use by the
Medical Cannabis Working Group members only

You can find additional copies of this questionnaire on line at www.dpfhi.org. Please mail your responses to Sen. Will Espero, Hawai'i State Capitol, Room 207, 415 S. Beretania, Honolulu, HI 96813 or fax to (808) 586-6361.)

A. Current state law allows for the acquisition of therapeutic or medical Cannabis (medical marijuana).

How difficult is it for you to acquire an adequate supply of medical Cannabis?

(please circle one)

1 2 3 4 5 (1 = no trouble at all 5 = very difficult)

B. What is the biggest problem you face in acquiring cannabis?

(check all that apply)

_____ Discomfort/fear in dealing in the black market

_____ Concern for personal safety

_____ Unreliability of supply

_____ Concern about contamination

_____ High cost

_____ Anxiety about law enforcement

_____ Other (please specify) _____

How much do you generally pay? _____

C. Would you prefer to acquire your Cannabis from a regulated store/shop/clinic?

(please circle one)

1 2 3 4 5 (1= would not prefer 5 = can't wait)

D. Current law also permits you to grow your own supply of Cannabis (within the limits of the law.)

Do you grow your own Cannabis? No ___ Yes ___ Sometimes ___ Never ___

If Yes, what are the largest obstacles to growing your Cannabis?

(check all that apply)

_____ Acquiring Seeds

_____ Disease / Rot

_____ Acquiring Clones

_____ Seasonal Changes

_____ Grow Space

_____ Lights

_____ Publicity / Confidentiality

_____ Knowledge

_____ Theft

_____ Experience

_____ Bugs / Rodents

_____ Fear of Arrest

_____ Other (please specify) _____

E. What other obstacles have you encountered with the program?

(check all that apply)

_____ Finding a physician willing to certify me

_____ Unwillingness of my regular doctor to certify me

_____ I'm a veteran and get health care through the V.A. or other federal entity

_____ Difficulties with my housing situation (please specify: landlord problems, public or federal housing, etc. _____)

F. How long did it take you to receive your "blue card" once all of your paperwork at been submitted to the Narcotics Enforcement Division of the Dept. of Public Safety? _____

G. Have you had employment-related problems?

(check all that apply)

_____ I am subject to routine drug testing

_____ I am subject to random drug testing

Does your employer have a formal policy on medical use of Cannabis? No ___ Yes ___ Don't know _____

What are the consequences of a positive drug test? _____

_____ Other employment-related problems. *(Please specify)* _____

H. Do you have a Caregiver as permitted by state law? No ___ Yes _____

If no, would you like to have a Caregiver supply your Cannabis? No ___ Yes ___ Definitely ___

Are you a Caregiver? No ___ Yes _____

Would you like help or information from an expert in learning how to grow your own Cannabis?

No ___ Yes ___ Maybe ___ Who would be the expert? _____

I. By your best guess, how much Cannabis do you consume in one average week?

Grams or ounces or joints (1 ounce=28 grams) _____

J. How do you consume your Cannabis?

(Check the 3 most applicable)

_____ Rolling paper/Blunt

_____ Pipe

_____ Water pipe/Bong

_____ Vaporizer

_____ Edible Goods/Tea

_____ Transdermal/Skin

_____ Sublingual/Under tongue

_____ Other *(please describe)*

K. How many years have you been registered as a medical Cannabis patient?

(Include Hawai'i and any other jurisdiction) _____

L. Have you ever had to show your State certificate to a law enforcement officer?

No ___ Yes ___ (please describe) _____

M. Have you had trouble traveling with your medicine? No ___ Yes _____

_____ Inter-island

_____ To the mainland or abroad

_____ If yes, what happened? _____

N. How satisfied are you in general with the State of Hawaii's current "Medical Marijuana" Statutes and/or Administrative Rules?

(circle one)

1 2 3 4 5 (1 = not satisfied at all 5 = extremely satisfied)

O. Which State Department should oversee Hawaii's "Medical Marijuana" program? Why?

_____ Keep it with the Department of Public Safety / Narcotics Enforcement Division

_____ Department of Health

_____ Department of Agriculture

_____ John A. Burns School of Medicine (UHM)

_____ Other (please specify) _____

P. Would you be willing to be interviewed by a member of the Hawaii Medical Cannabis Working Group? (confidentially, of course)

No ___ Yes ___ (Please contact me at _____)

Q. What additional comments, questions or concerns would you like to share with the Working Group?

(use additional sheets if desired)

MAHALO FOR YOUR PARTICIPATION! THE AIM OF THIS QUESTIONNAIRE IS TO IMPROVE HAWAI'I'S PROGRAM FOR THE BENEFIT OF EVERYONE.

APPENDIX K

(Revised 01/05/10)

HAWAII MEDICAL CANNABIS WORKING GROUP QUESTIONNAIRE 10/09

A. CURRENT STATE LAW ALLOWS FOR THE ACQUISITION OF THERAPEUTIC OR MEDICAL CANNABIS (MEDICAL MARIJUANA). HOW DIFFICULT IS IT FOR YOU TO ACQUIRE AN ADEQUATE SUPPLY OF MEDICAL CANNABIS?

(Circle one, being 1 = no trouble at all 5= very difficult)

1	2	3	4	5	NO ANSWER
11	1	17	18	39	15

B. WHAT IS THE BIGGEST PROBLEM YOU FACE IN ACQUIRING CANNABIS?

(Check all that apply)

Discomfort/fear in dealing in the black market	Concern for personal safety	Unreliability of supply	Concern about contamination	High cost	Anxiety about law enforcement
70	59	63	43	73	80

OTHER (SPECIFY)

1. UNKNOWN STRAINS
2. HARD TO GROW
3. WE NEED CANNABIS CLUBS (SAFE ACCESS)
4. NEIGHBORHOOD THIEVES
5. NEIGHBORS STEALING SUPPLY.
6. HARSH PENALTIES/LE MISBEHAVIOR
7. NO SAFE PLACE TO GROW
8. FEAR OF BURGLARY OF PLANTS
9. SOCIAL STIGMA

HOW MUCH DO YOU GENERALLY PAY?

Zero	Less \$100	\$100 – 200	\$201 – 300	\$301 – 400	\$401 +	NO ANSWER
4	8	11	14	20	3	41

C. WOULD YOU PREFER TO ACQUIRE YOUR CANNABIS FROM A REGULATED STORE/SHOP/CLINIC?

(Circle one, being 1 = would not prefer 5 = can't wait)

1	2	3	4	5	No Answer
12	3	9	10	63	4

CURRENT LAW ALSO PERMITS YOU TO GROW YOUR OWN SUPPLY OF CANNABIS (WITHIN THE LIMITS OF THE LAW.) DO YOU GROW YOUR OWN CANNABIS?

No	Yes	Sometimes	Never	No Answer
18	53	23	5	2

(Revised 01/05/10)

√ IF YES, WHAT ARE THE LARGEST OBSTACLES TO GROWING YOUR CANNABIS?

(Check all that apply)

Acquiring Seeds	Acquiring Clones	Grow Space	Publicity / Confidentiality	Theft	Bugs/Rodent	Disease/Rot
53	381	35	50	59	30	34
Seasonal Changes	Lights	Knowledge	Experience	Fear of Arrest	*Other	NO ANSWER
21	24	30	27	57	11	10

√ OTHER (SPECIFY)

1. EXISTING LAWS NOT ADEQUATE OR PRACTICAL ON THE ADEQUATE SUPPLY FOR CERTAIN PARTICIPANT.
2. EXISTING LAWS ARE NOT ADEQUATE OR PRACTICAL FOR AMOUNTS ALLOWED.
3. CONSTANT HELICOPTER HARASSMENT.
4. SPOUSE OF ACTIVE DUTY MILITARY & RETIRED.
5. EXTREMELY TIME CONSUMING.
6. LE BULLIES
7. PEOPLE STEAL IT.
8. HELICOPTERS

F. WHAT OTHER OBSTACLES HAVE YOU ENCOUNTERED WITH THE PROGRAM?

(Check all that apply)

Finding a physician willing to certify me.	Unwillingness of my regular doctor to certify me	I'm a veteran and get health care through the V.A. or other federal entity.	NO ANSWER
36	27	9	29

√ DIFFICULTIES WITH MY HOUSING SITUATION.

Landlord problems	Public or Federal Housing	Etc.
		<p style="text-align: center;">20</p> <p>11 -(did not specify)</p> <p>1- Neighbors</p> <p>1- lease prohibits growing</p> <p>1 – job</p> <p>1 – finding a good place that is safe.</p> <p>1- small apartment/ no room</p> <p>1 – housing authority will stop your help if you have medicine</p> <p>1- Landlord "not legal"</p> <p>1- Landlord problems</p>

(Revised 01/05/10)

F. HOW LONG DID IT TAKE YOU TO RECEIVE YOUR "BLUE CARD" ONCE ALL OF YOUR PAPERWORK AT BEEN SUBMITTED TO THE NARCOTICS ENFORCEMENT DIVISION OF THE DEPT. OF PUBLIC SAFETY?

No answer	0-3 weeks	1 month +	2 months	Over 2 months	Pending	Other
36	3	11	30	13	4	4 *

Never received a blue card, asked about a dispensary.

G. HAVE YOU HAD EMPLOYMENT-RELATED PROBLEMS?

(Check all that apply)

I am subject to routine drug testing	I am subject to random drug testing	No Answer
6	24	71

DOES YOUR EMPLOYER HAVE A FORMAL POLICY ON MEDICAL USE OF CANNABIS?

No	Yes	Don't know	No Answer
24	12	16	49

WHAT ARE THE CONSEQUENCES OF A POSITIVE DRUG TEST?

Lose your job	Don't know	No Answer
23	6	72

OTHER EMPLOYMENT-RELATED PROBLEMS. (Please specify) HARASSMENT

H. DO YOU HAVE A CAREGIVER AS PERMITTED BY STATE LAW?

No	Yes	No Answer
77	15	9

IF NO, WOULD YOU LIKE TO HAVE A CAREGIVER SUPPLY YOUR CANNABIS?

No	Yes	Definitely	NO ANSWER
41	27	13	20

ARE YOU A CAREGIVER?

No	Yes	No Answer
67	17	17

(Revised 01/05/10)

WOULD YOU LIKE HELP OR INFORMATION FROM AN EXPERT IN LEARNING HOW TO GROW YOUR OWN CANNABIS?

No	Yes	Maybe	NO ANSWER
26	31	24	20

✓WHO WOULD BE THE EXPERT? SELF
OSTERDAM UNIVERSITY

I. BY YOUR BEST GUESS, HOW MUCH CANNABIS DO YOU CONSUME IN ONE AVERAGE WEEK?
(Grams or ounces or joints (1 ounce = 28 grams))

0 – 1 grams	2-5 grams	7-12 grams	14-19 grams	20-27 grams	1-5 joints	6-7 joints	Less than 1 oz	1 – 2 ounces	3 plus ounces	No Answer
5	8	13	9	4	5	4	10	19	1	23

J. HOW DO YOU CONSUME YOUR CANNABIS?

(Check all that apply)

Rolling paper/Blunt	Transdermal/Skin	Pipe	Sublingual/Under tongue	Water pipe/Bong	Vaporizer	Edible Goods/Tea	No Answer
66	3	58	3	42	34	44	4

OTHER (please describe) Tincture THC Drops

K. HOW MANY YEARS HAVE YOU BEEN REGISTERED AS A MEDICAL CANNABIS PATIENT?

0	1-3 weeks	1 – 11 months	1 – 4 years	5 yrs & over	10 yrs & over	Pending	Other	No Answer
2	12	12	33	13	1	2	2*	22

*Since it began – started with Dr. Weiner.

L. HAVE YOU EVER HAD TO SHOW YOUR STATE CERTIFICATE TO A LAW ENFORCEMENT OFFICER?

No	Yes
78	16

IF YES, WHAT HAPPENED? (SPECIFY)

1. GOT STOPPED 3 YRS AGO, AND SHOWED THEIR CARD TO CLEAN UP FILM CANISTER OF WEED.
2. WHEN PLANTS WERE STOLEN AND REPORTED THE LOSS.
3. CONSTANT HELICOPTER HARASSMENT.
4. POLICE VIEWED CARD AND LEFT WITHOUT INCIDENT.
5. AIRPORT/SPEEDING
6. NEIGHBORS CALLED POLICE AND I HAD ONLY MY 7 PLANTS AS INSTRUCTION DICTATES.
7. AN OFFICER SMELLED MY SMOKE AND KNOCKED ON MY DOOR.

(Revised 01/05/10)

M. HAVE YOU HAD TROUBLE TRAVELING WITH YOUR MEDICINE?

No	Yes	Inter-island	Mainland or Abroad
52	30	24	22

IF YES, WHAT HAPPENED? (SPECIFY)

1. NEARLY ARRESTED AT KONA AIRPORT. TSA TURNED OVER TO AIRPORT SECURITY & THEY IN TURN CONTACTED THE POLICE. SINCE HPD DID NOT SHOW UP, INDIVIDUAL WAS RELEASED; HOWEVER MARIJUANA WAS CONFISCATED.
2. AIRPORT SECURITY FOUND AND TOOK INDIVIDUAL CANNABIS MEDICINE.
3. NOTHING IS ALLOWED.
4. PARANOID
5. RANDOM BODY SEARCH
6. FEAR
7. ANXIETY
8. DID NOT TAKE MARIJUANA OUT OF FEAR.
9. TOO AFRAID TO TRY
10. COULD NOT TRAVEL WITH IT.
11. PULLED OFF PLANE, THAN ALLOWED BACK ON WITH MY MEDICINE AFTER SHOWING BLUE CARD.
12. TAKEN AWAY
13. TOO AFRAID TO CARRY MEDICINE THROUGH AIRPORT TSA.
14. TAKEN FROM ME IN CAR.
15. DON'T TRAVEL WITH IT. BUY IT AT DESTINATION
16. WILL NOT LET YOU TRAVEL

N. HOW SATISFIED ARE YOU IN GENERAL WITH THE STATE OF HAWAII'S CURRENT "MEDICAL MARIJUANA" STATUTES AND/OR ADMINISTRATION RULES?

(Circle one, being 1 = not satisfied at all 5 = extremely satisfied)

1	2	3	4	5	No Answer
32	25	22	6	5	11

O. WHICH STATE DEPARTMENT SHOULD OVERSEE HAWAII'S "MEDICAL MARIJUANA" PROGRAM?

Keep it with DPS/Narcotics Enforcement Division	Dept. of Health	Dept. of Agriculture	JABSOM	Other (please specify)
6	68	29	10	12 1) Co-op 2) No preference, whichever will be able to move this forward 3) New oversight –Dept. of Cannabis 4) none- FDA if mj is sold or distributed.

(Revised 01/05/10)

P. WOULD YOU LIKE TO BE INTERVIEWED BY A MEMBER OF THE HAWAII MEDICAL CANNABIS WORKING GROUP? (CONFIDENTIALLY, OF COURSE)

No	Yes	No Answer
35	59	7

Q. WHAT ADDITIONAL COMMENTS, QUESTIONS OR CONCERNS WOULD YOU LIKE TO SHARE WITH THE WORKING GROUP?

Comment #1:

I'm as concerned by the people in jail who have been caught without medical certification as those who can afford to pay for the appropriate fees. It's a minor drug – should be grown under controls to see it's pure and taxes should be paid to the state.

Comment #2:

I want the legal lies to stop. I honestly believe that Hawaii's economic savior is HEMP/CANNABIS, instead of tourism.

Comment #3

1. Safe access to patients who do have that ability.
2. What is an adequate supply – 3oz is not. The Federal 5 "Rosenfeld" gets 21 oz. every 25 days – a 24 oz – 60 day – limit is ok per patient.
3. Co-ops i.e. or collectives to grow cannabis for medical purposes: 1 patient rule is not enough.
4. Interisland travel with medical cannabis allowed.
5. Reciprocity with all other medical cannabis states.
6. Change to Dept. of Health to regulate.
7. Wellness centers i.e. medical cannabis dispensaries to those who are unable to grow their own.

Comment #4

One of the first changes in the law would be to allow all the plants to be budding. No restrictions on the number of budding plants. Over the last three years I have had to kill 13 plants because I was over my number of budding plants. It cost money and time.

Second, I would extend the number of plants from seven to twelve. With only seven plants I have difficulty growing an adequate amount. I am a 100% disabled American veteran and have a lot of scar tissue (pain) in my body and I find it difficult to grow an adequate amount, especially in the winter, for my high level of consumption.

Third, extend the amount of on hands buds to ten ounces per person.

(Revised 01/05/10)

Comment #5

We really need a regulated cannabis store – it also would be helpful to have a meeting closer to the ocean view area.

Comment #6

We need badly, a safe environment to purchase our medical marijuana. The republicans in office (Lingle) are living in the dark ages and need to be forced to follow other states protocol (California) Cannabis clubs or name to be enlightened to instigate our Medical Policy. It's a crying shame to have to wait years for the Governor to leave office. Along with her economic mess she's got us into, this is just adding fire to her suppression of Human Rights.

Comment #7

I am chair of Big Island chapter of the Americans for Safe Access. We have contributed testimony to the legislative committees to change the medical cannabis laws in the state...to no avail. Yet, we are undaunted and will continue to seek reform and liberalization of Medical Cannabis laws here.

Comment #8

As a patient of Medical Cannabis, I would like to see the following:

- a. Safe access for patients
- b. Inter-island travel with Medical Cannabis to be allowed.
- c. Reciprocity with all other Medical Cannabis states.
- d. Co-ops to grow cannabis for medical purposes.

Comment #9

The number of plants allowed should be increased.

Comment #10

1. Why are there no dispensaries?
2. Why not more than 7 plants?

Comment #11

The list of license users was released to Peter Sur at the Hilo Tribune Herald last year. That is one major reason to change the overseeing of the program to the Dept. of Health. There are laws governing our medical information and Dept. of Public Safety broke these laws. It is a deterrent to people signing up also. (See attached letter to Senator Espero)

Comment #12

(See attached)

(Revised 01/05/10)

Comment #13

I am a California Medical Card Holder and member of several legal cooperatives. Their fundamental guidelines or contract with members is critical if implemented properly. I would be happy to share copies of collective contracts that could be rewritten for Hawaii. I participate as ASA Honolulu Chapter member and have been producing Tincture Rock ? baked goods and delivering for free.

Comment #14

(See attached)

Comment #15

Thank you. Call me if you have any questions. I caregive for 3 others.

P.S. Lot of theft here in Oceanview, Hawaii.

Comment #16

Thank you for picking up the ball that our Governor dropped. She would have needed a court order before doing anything to help patients. Now that President Obama has directed the D.O.J. to stop going after MMJ patients and complying dispensaries, she (Lingle) won't have that automatic response to justify her lack of support. "It's still illegal under Federal Law,...but I'll bet she doesn't change her position. At this point it's become a moral issue, since the government still chooses to ignore an ever-growing mountain of scientific data.

Comment #17

We really need a regulated cannabis store. It also would be helpful to have a meeting closer to the Ocean View area.

Comment #18

1. Too few plants are permitted
2. Important medical conditions do not qualify
3. I would be happy to assist the working group with a website and email communication of research. (See attached)

Comment #19

I would like to see a co-op situation, where people can help each other find patients for excess growth and work together for everyone's benefit.

Comment #20

(See attached)

(Revised 01/05/10)

Comment #21

Thank you for your time. In life we are blessed with living life and the living, natural, world around us. I have been life dissolve from the cancer filled bodies of both my mom and dad. Both grew tremendous in the light and spirit as they're flesh decayed. My mom used the only effective symptoms. It was too hard to find quality, safe, medical and spiritual cannabis.

Comment #22

Whichever department can move this forward, eliminate the catch-22 for patients who have nowhere to go to legally, safe by obtain meds. Obtain input from knowledgeable patients/caregivers about growing (male vs. female plants, what constitutes mature, how much cannabis does a patient require). Please allow med patients and caregivers a chance to create collectives/cooperatives for growing and distributing safely.

Comment #23

Cannabis has saved my life. Why should I feel like a criminal to use this herb that has easily replaced 6 medications? It is not cost-effective and the side effects of my other medications caused only more medical conditions.

Comment #24

Would like a system similar to California Medical Cannabis System.

Comment #25

I believe the easiest way to go is to seek the guidance of the courts, through an original Writ of Mandate in Hawaii Supreme Court regarding our unique intrastate travel that necessitates federal aviation and maritime jurisdictions and bring all parties to the table in a modular (island by island council) that includes the local mayors and is overseen by the Governor & Supreme Court. It is a matter of reason.

Further, I am willing, per Mr. Peter Pan's report, as a priest monk, to facilitate the acquisition of medicine by patients and the development of a clinic and socially acceptable dispersal point for patients. I will help in any way I can to for patients. I will help in any way I can to put a stop to what is arguably, a bigger rift in society than the Viet Name War. Barring all of this – Pres. Obama could easily sign an executive order taking marijuana off schedule I.

Comment #26

Why? If we have a license, do we not have a dispensary?

(Revised 01/05/10)

Comment #27

If I have a license why am I not able to smoke it a freely like those who smoke cigarettes in public, when cigarettes are proven to harm those who do not even smoke.

Comment #28

Why is alcohol dispensed out of liquor stores and gas stations? When at least every year some one/people die from drunken driving accidents, and cause fights at bars. Have you ever heard of someone falling asleep @ the wheel because they were "too stoned" to drive? Why, if something that so widely takes lives every year gets sold so openly, can't I go down to a dispensary and buy a bag of weed? The world would be a cleaner and better place if all tobacco companies where replaced with pot dispensaries, or cigarette rolled weed companies.

Comment #29

We need our medicine to be readily available. It would be nice to have some kind of co-op with farmers that could supply the patients with high quality medical cannabis.

Comment #30

We need our medical to be readily available for all patients. State controlled company that buys the product like coffee is today in our community.

Comment #31

I need to grow more plants because I use it in cooking.

Comment #32

I don't understand how we can cut schooling on Fridays when education in Hawaii has been known to be so poor and yet still give funding to the marijuana eradication program. How is it okay to be cutting government jobs such as adding furlough days to court and still be enforcing discipline upon marijuana users when they will only have certain days to appear in court due to job cuts? How is taking money from our hurricane fund even an option to helping our school systems? And cutting unnecessary funding for marijuana eradication is not?

Comment #33

We need a clinic with a grower's co-op that all excess high grade products can be purchased by the clinic and sold for other patients through the safest means. Treat the herb as the coffee is marketed here in Kona.

Comment #34

We need a place where we can get medicine and clones.

Comment #35

I have a seizure disorder. Get tired and cramps if I type or write. Please contact me!

(Revised 01/05/10)

Comment #36

Need for Dispensary and stop helicopter harassment.

Comment #37

Would like "on going" news on Hawaii State updates.

Comment #38

Remove law enforcement from this situation, unless you want to use the drivers license division people.

Comment #39

I'm concerned about the police taking my plants even though I have a blue card.

Comment #40

See N & O Plus county of Hawaii police and prosecutors need to respect "Lowest Law Enforcement" priority. Police here are retrograde Cro-Magnons.

Comment #41

It would be very nice to have clubs, like California.

Comment 11

Nov. 7, 2009

Dear Senator Will Espero,

Thank you for your interest in learning more about medical mj and helping those that need the medicine for whatever reason. My interest in it is personal but I come with a unique perspective of having been a health care provider and what that world is like. I am a [REDACTED] [REDACTED] I was on the [REDACTED] and witnessed firsthand the addiction problems chronic pain people face. Unfortunately, [REDACTED] and [REDACTED] I was forced to medically retire and deal with chronic pain myself. With the addiction problems fresh in my mind, I tried marijuana and realized how well it worked on my pain without leaving me a drooling mess; which was a side effect of AMA medications prescribed for my pain. I could still function and be productive at home as well as spend time with my grandchildren without sleeping thru their visit. I signed up for medical marijuana in March of 2003. I will attempt to educate you on the problems, trials and tribulations, and difficulties medical mj patients face thru my own experiences.

The first problem all of us face is finding a doctor who will prescribe m.j. as a medicine. One doctor refused saying she didn't want every drug addict at her door begging for drugs. Another doctor uses a Psychologist to screen the patients. Anyone seeing this Psychologist has to pay him also so there is a double charge of which some has to be cash up front. This cost is formidable for sick people on a fixed income. Another doctor lives in Hawi, which is a 2 hr drive for those from the east side to see this doctor which presents its own set of problems: finding a ride or gas money to see him as well as the trip taking a whole day to do. With the Obama administration putting out a statement that they won't prosecute or go after medical marijuana users that stay within their state laws, hopefully a few more doctors will let go of their fear of losing their medical license if they prescribe medical marijuana. Unfortunately though, finding a doctor right now is a difficult task for a sick person to achieve.

The second problem with licensing is that it has to be done yearly. For all the reasons above, cost etc..... at the very least the license needs to last for several years to take the pressure off the sick person. With licensing currently taking 4 to 6 weeks for a person to receive their license, just 10 months after being certified, we have to go thru the whole thing again.

Last year the department overseeing the medical marijuana program inadvertently gave the list to the Hawaii Tribune Herald. When I read the paper that morning and saw that Peter Sur, the author of the article, had been given the list of medical m.j. patients, I was scared and livid. This was in direct violation of medical privacy laws. I called Peter Sur immediately and he bragged about it and even told me the name of the person who emailed him the list. I then called the Department of Narcotics and informed them of the article, they didn't have a clue that the list had been compromised. I do not find their apology enough nor do I think we are safe from it happening again. Prescribing medicine to a patient is a health issue and the program should be overseen by the Department of Health. This is one of the major road blocks from more people taking advantage of the program.

Once we are licensed the next step is to find marijuana. The current cost is expensive, \$300 to \$400 an ounce, if you can find it, that is. This is a gray area for growers, one cannot sell m.j. legally. So anyone with extra cannot legally sell it to people who need it. Some form of buyers clubs need to be established

In a perfect medical marijuana world there would be buyers clubs for all stages. Seedlings or clones for sale so people can grow their own. Different strains of dried pot for sale so people too sick or no place to grow can easily get their supply of medicine at a reasonable price. 8 ounces of dried pot allowed on hand for all licensed users. 14 plants in different stages of growth to give the licensed grower a steady supply. No penalties for licensed growers selling clones or seedlings to licensed users. No penalties for licensed growers selling dried pot to licensed users. No penalties for licensed users travelling Interisland or to the mainland with their medicine. A license lasting for 5 years rather than just 1 year. Doctors freely writing prescriptions for medical m.j. without fear of losing their medical license. And the Department of Health would be the overseer of the program.

It feels like the cart was made before the horse was bought in the case of legalizing medical marijuana. We are allowed to use pot as medicine but all the difficulties mentioned in this letter make it difficult if not impossible for people to keep a steady supply of meds on hand. I am willing to testify or talk to anyone that can help facilitate more user friendly conditions for medical marijuana users. Thank you for your time and effort on this matter.

[REDACTED]

[REDACTED]

Underlying all of my concerns is the attitude the Maui Police Dept takes toward medical marijuana. Chief Yabuta was recently quoted in the Maui News as saying something to the effect that he considers marijuana to have no drug value in terms of medical. This is prehistoric in today's science-driven climate. It is tantamount to saying the sun doesn't rise in Maui and getting away with it. The Maui Police Dept.'s attitude is nothing less than cruel. If you have ever known anyone who is suffering severe chemotherapy reactions, nausea and appetite loss due to anti-cancer, or HIV drugs, knows without a doubt that medical marijuana can bring immediate, side-effect free relief to these people. To force them to grow their own which will take 8-10 weeks, if they can find seeds or clones which would be considered illegal, and after waiting 10 weeks or more for their blue card is nothing short of cruel. Just because a few MMJ patients abuse the system is no reason to punish everyone. It is way past time for the powers that be and can, to step up to the plate and put an end to this tyranny. There are no objective reasons why MMJ patients can't have access to their medications immediately upon certification by their doctor; the Obama Administration has gotten out of the way to allow the states their own freedom.

I use up to one ounce per week, between tinctures, edibles and some smoking/vaporizing. I will use up my limit within 3 weeks and there is no legal way to supplement the deficiency.

Also, invariably, some plants get sick and die. That decreases an already puny supply. The winter months are not friendly for growing due to wet, mold and weak sun and overcast skies.

The point here is that we need to be able to grow enough for our needs and keep enough of a supply to get us through the poor growing season.

And in order to do all this we need to be able to obtain LEGALLY, seeds or clones to get started.

The way the program is enacted now is similar to experiments scientists do with mice; giving them something they want/need and then preventing them from getting it. Except in this case the powers that be are doing this out of spite and cruelty.

The whole idea of oversight is to take this out of the hands of the police. They do not make or prevent the laws to obtain other legal drugs so why should they with MMJ? It needs to be overseen by a friendly "health and well being oriented" department.

Thank you for listening.

Q. What additional comments, questions or concerns would you like to share with the Working Group?

(use additional sheets if desired) THE BIGGEST PROBLEMS WITH HAWAII'S DO

DOCTORS ARE IN FEAR OF AILING A PRESCRIPTION FOR MARIJUANA, BECAUSE OF THE
CH LOSING THEIR LICENSES FROM THE DEA. THE LAW ENFORCEMENT HERE IN
HAWAII, INTIMIDATE PATIENTS & THREATEN INCARCERATION & FORFEITURE OF YOUR
PROPERTY INCLUDING YOUR HOME! ALL BECAUSE YOU'RE SICK & FIND CANNABIS TO
BE HELPFUL IN REDUCING PAINMENTS. THE HAWAII LAW FAILS EXACT ON ADEQUATE
SUPPLY. ACCORDING TO FEDERAL GUIDELINES ALL PATIENTS IN THE U.S. SHOULD
HAVE A 3 MONTH SUPPLY OF THEIR MEDICATION IN CASE OF EMERGENCY. WASH
STATE'S LAW EFFECTIVELY SOLVED THIS PROBLEM BY ALLOW MED. MAR. P
TO HAVE 24 OUNCES ON HAND, & THE PROGRAM IS ADMINISTERED BY
THE DEPT. OF HEALTH. WE NEED TO REMOVE THE DEPT. OF PUBLIC SAF
FROM HAVING ANYTHING TO DO WITH THIS PROGRAM OR ANY OTHER THAT
WILL SOMEONE'S HEALTH. MY NAME, ADDRESS & OTHER VITAL INFO REGARDING
MY MED. MAR. LICENSE WAS EMAILED TO A LOCAL NEWSPAPER, ON THE
BILL I DROPPED JUST OVER A YEAR AGO. NOT GOOD. THAT SORT OF THREATEN
RESPONSIBILITY COULD HAVE RUINED MY LIFE & MY WIFE'S (TOP SECRET CLEAR
WITH D.O.S.)
THE FEAR & INTIMIDATION FROM LAW ENFORCEMENT NEEDS TO STOP. THAT
IS ANOTHER BILL ISSUE. DO YOU CALL THE POLICE AFTER SOMEONE STEAL
YOUR MEDICINE? IF YOU WANT TO END UP IN JAIL GO AHEAD. IF EVER
WAS ALLOWED TO GROW THEIR OWN, YOU WOULDN'T HAVE AS MUCH TROUBLE. I DON'T SEE;

MAHALO FOR YOUR PARTICIPATION! THE AIM OF THIS QUESTIONNAIRE
IS TO IMPROVE HAWAII'S PROGRAM FOR THE BENEFIT OF EVERYONE.

JUMPING OVER FENCES TO STEAL AVOCADOS. IN A NUTSHELL, REMOVE THE POLICE

Page 3 of 3

HAWAII MEDICAL CANNABIS WORKING GROUP QUESTIONNAIRE

FROM THIS PROCESS COMPLETELY, ALLOW PATIENTS TO GROW & STORE MORE PLANTS THAN
CURRENTLY AVAILABLE. IF PEOPLE CAN'T GROW THEIR OWN WE NEED LOCATIONS TO GROW
W/2 MEDICINE AT A REASONABLE COST NOT \$400 A OUNCE, \$100 A OUNCE
WOULD BE FAIR. IF LAW ENFORCEMENT WASN'T INVOLVED MY DOCTOR WOULD WRITE
PRESCRIPTIONS.

Medical Conditions

The following table lists the qualifying medical conditions that are listed in state medical marijuana laws. Many of the qualifying medical conditions overlap. Other medical conditions qualify in some states if, in the opinion of your doctor, use of medical marijuana would be an appropriate treatment.

Named medical condition	AK	CA	CO	HI	MI	MT	NV	NM	OR	RI	VT	WA
AIDS	X	X	X	X	X	X	X	X	X	X	X	X
Amyotrophic lateral sclerosis	-	-	-	-	X	-	-	X	-	-	-	-
Agitation of Alzheimer's disease	-	-	-	-	X	-	-	-	-	X	-	-
Anorexia	-	X	-	-	-	-	-	-	-	-	-	-
Anorexia/cachexia	-	-	-	-	-	-	-	X ^a	-	-	-	X ^c
Arthritis	-	X	-	-	-	-	-	-	-	-	-	-
Cachexia	X	X	X	X	X	X	X	-	X	X	X ^k	X
Cancer	X	X	X	X	X	X	X	X	X	X	X	X
Cramping	-	-	-	-	-	-	-	-	-	-	-	X ^c
Crohn's disease	-	-	-	X	X	X	-	X	-	X	-	X
Epilepsy	X	X	X	X	X	X	X	X	X	X	-	X
Glaucoma	X	X	X	X	X	X	X	X	X	X	-	X
Hepatitis C	-	-	-	-	X	-	-	X ^b	-	X	-	X
HIV	X	X	X	X	X	X	X	X	X	X	X	X
Hospice patients	-	-	-	-	-	-	-	X	-	-	-	-
Migraine	-	X	-	-	-	-	-	-	-	-	-	-
Multiple sclerosis	X	X	X	X	X	X	X	X	X	X	X	X
Muscle spasms	-	X ⁱ	-	-	X ^o	X ⁱ	X ⁱ	-	-	X ^o	-	X ^a
Muscle spasticity	X	-	X	X	-	-	-	-	X	-	-	-
Nail psoriasis	-	-	-	-	X	-	-	-	-	-	-	-
Nausea	X	X ^a	X	X	X ^a	X ^a	X ⁿ	-	X	X ^a	X ^u	X ^c
Nausea/vomiting	-	-	-	-	-	-	-	X ^k	-	-	-	-
Nervous system disorders	-	-	X ^g	-	-	-	-	-	-	-	-	-
Pain	X ^g	X ^g	X ^g	X ^g	X ⁱ	X ^h	X ^a	X ^j	X ^u	X ⁱ	X ^a	X ^k
Painful peripheral neuropathy	-	-	-	-	-	-	-	X	-	-	-	-
Post-traumatic stress disorder	-	-	-	-	-	-	-	X	-	-	-	-
Seizures	X	X	X	X	X	X ⁱ	-	X	X	X	X	X ^c
Spasticity	-	-	-	-	-	-	-	X ^{d,k}	-	-	-	X ^c
Vomiting	-	-	-	-	-	-	-	-	-	-	-	X ^c
Wasting	-	-	-	-	-	-	-	-	-	-	-	X ^c

Wasting syndrome	-	-	-	-	X	X	-	-	-	-	X ^a	X ^c
------------------	---	---	---	---	---	---	---	---	---	---	----------------	----------------

- ^a severe
- ^b when currently receiving antiviral treatment
- ^c when unrelieved by standard treatments or medications
- ^d due to damage to the nervous tissue of the spinal cord
- ^e severe and persistent
- ^f persistent
- ^g chronic
- ^h severe or chronic
- ⁱ severe or persistent
- ^j severe and chronic
- ^k intractable
- ^l severe, debilitating and chronic

Acquired Immune Deficiency Syndrome (AIDS)

AIDS is a disease of the human immune system caused by the human immunodeficiency virus (HIV). The condition progressively reduces the effectiveness of the immune system and leaves individuals susceptible to opportunistic infections and tumors. Nausea, anorexia (loss of appetite), and wasting are common symptoms of AIDS

Cachexia

Cachexia is unintended weight loss, muscle atrophy, fatigue, weakness and significant loss of appetite. Cachexia is seen in patients with cancer, AIDS, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).

Cancer

Cancers are diseases in which cells display uncontrolled growth, invasion of adjacent tissues, and sometimes metastasis (spreading to other locations in the body). Symptoms of cancer and its treatment can include pain, nausea, vomiting and diarrhea.

Crohn's Disease

Crohn's disease is an inflammatory, autoimmune disease that may affect any part of the gastrointestinal tract. Its primary symptoms include abdominal pain, diarrhea, vomiting, and weight loss.

Epilepsy

Epilepsy is a chronic neurological disorder characterized by recurrent unprovoked seizures. Side effects of anticonvulsants used to treat the disorder can include dizziness, drowsiness, unsteadiness, nausea, vomiting and headaches.

Glaucoma

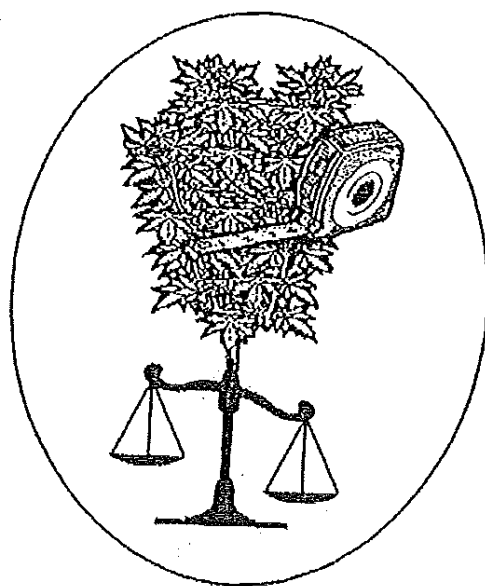
Glaucoma is a type of optic neuropathy that affects the optic nerve. Raised intraocular pressure is a significant risk factor for developing glaucoma. Worldwide, it is the second leading cause of blindness.

Multiple Sclerosis

Multiple sclerosis (MS) is an autoimmune disease that arises from an unknown cause. In multiple sclerosis, the body's immune system attacks the central nervous system (brain and spinal cord). Neurological symptoms of the disease include muscle weakness, muscle spasms or difficulty in moving, difficulties with coordination and balance, problems with speech or swallowing, visual problems, fatigue, acute or chronic pain, and bladder and bowel difficulties. Cognitive impairment of varying degrees and depression or unstable mood are also common.

CANNABIS YIELDS AND DOSAGE

A Guide to the Production and Use of Medical Marijuana



CHRIS CONRAD

Court-qualified cannabis expert
Director, Safe Access Now

CREATIVE XPRESSIONS

PO Box 1716, El Cerrito CA 94530 • www.safeaccessnow.net

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this document, available on the web, provides evidence about how much cannabis is necessary

Subject: Medical Conditions List
From: [REDACTED]
Date: Sun, 23 Oct 2009 12:28:10 -1000
To: "info@dplhi.org"

Aloha All!

Just signed up today

As a Non-combat Disabled Vet, I talk to many Veterans, both socially and thru the VA Clinic in [REDACTED]. The MOST IMPORTANT issue for Veterans is adding PTSD to the list of Medical Conditions. It is well known among Vets (including many health-care professionals @ the VA) that Cannabis is the best medicine to control PTSD. Literally every Vet I have met who has PTSD uses Cannabis to help them calm down.

I have [REDACTED] and [REDACTED] who work in government and police, and have been lobbying them over the Medical Cannabis issue. (there is alot of support among the police officers on the beat, unlike their supervisors!)

Attached is a letter to Rep Hanohano

Aloha from [REDACTED] and Mahalo for all your efforts!

[REDACTED]

Subject: HB 1635
From: [REDACTED]
Date: Sun, 15 Feb 2009 10:45:26 -1000
To: "rephanohano@dCapitol.hawaii.gov"

Aloha Representative Hanohano

My name is [REDACTED] and I have lived in [REDACTED]. I am [REDACTED] years old and have [REDACTED] for over 20 years.

I have heart disease and face surgery next year, and I have back problems including muscle spasms. The good people at the Veterans clinic [REDACTED] Hospital, tried to help me deal with my back problems. After trying several medicines, it became clear that, although they helped, they were so strong that I could not do my job. I had problems paying attention, and remembering what I was doing next. Finally it was recommended that I try medical marijuana, and I got my first permit about six years ago. It not only helped me, but because I did not need to use it during the day, it allowed me to function. I NEVER smoke pot on the job, I have too much respect for [REDACTED]. I want to always be 100%, which wasn't happening with the pills I tried, as they had to be taken all the time.

I want to thank you for the effort you are making to help the Med Marijuana community, however, I have misgivings about HB 1635. I have no problem with the record keeping aspect; it is common sense. My problem is with (per Trib Herald story) "Any physician who prescribes marijuana to a person "without a bona fide physician patient relationship". etc.

The biggest problem Med Marijuana patients have, is finding a Doctor, and finding a Doctor who doesn't charge an arm and a leg. The main reason it is a problem, is that many doctors do not want to register as M.M. doctors, in part because they don't want to "go public", and in part because they were afraid to after Ed Kubo threatened doctors with federal prosecution (As you know, the ACLU forced Kubo to issue a retraction, but the damage was already done). Consequently, many doctors refer their patients to doctors who dispense M.M. certificates. The way HB 1635 is described by the press, it seems it would make it too easy for anti-medical marijuana people in government to harass doctors who, it could be claimed did not have "a bona fide physician patient relationship". As example, my doctor is very thorough, I must provide abstracts of my VA med records for the past year, and they must show that my disability is ongoing. However, my doctor is retired from general medical service, and mostly works with M.M. patients like me because he wants to help us. The reason Doctor [REDACTED] for example, has so many M.M. patients, is because NOBODY ELSE WILL, and she, also, is just trying to help. My doctor, by the way, been very helpful helping me prepare for my heart surgery, as he is familiar with the field.

There are, however, doctors not as scrupulous as mine, who are only in it for the kaha. Some charge so much (up to \$500) that someone with little income would be tempted to SELL pot just to afford the certificate! My doctor charges only \$125, (plus \$25 to the state), and if he was required to do a complete physical, (which is unnecessary, as the doctors at the VA already did), my doctor would be forced to charge MUCH more, and my VA medical does not cover the cost of my certificate, as it is a Federal entity. (That does not mean that they are opposed to Medical Marijuana, in fact, it is well known in the Veteran community that Marijuana is BY FAR the BEST medicine for Vets with PTSD, (including me), and we all wonder why PTSD is not included in the law. Perhaps you

Medical Conditions List

could do something about that?

Ma'halo plenty for your time, and if I can help in any way, please feel free to contact me ([REDACTED]

Aloha,
[REDACTED]

HB 1635.eml Content-Type: message/rfc822
Content-Encoding: 7bit

APPENDIX L



DEPARTMENT OF VETERANS AFFAIRS

Medical Center
5500 Armstrong Road
Battle Creek, MI 49037-7314

In Reply Refer To: 515/11

JUN 19 2009

Mr. Martin H. Chilcutt
Executive Director
Veterans for Medical Marijuana Access
1414 Low Road
Kalamazoo, MI 49008

Dear Mr. Chilcutt:

This is in response to your correspondence dated June 11, 2009, regarding medical marijuana protocols at the Veterans Affairs Medical Center, Battle Creek.

The Office of the General Counsel has determined that no VA physician shall complete any forms for the State of Michigan for medical marijuana. However, for patients whose treatment plan from a non-VA physician includes use of medical marijuana, presence of marijuana in a urine drug screen is acceptable.

It is the goal of the Battle Creek VA Medical Center and its Community Based Outpatient Clinics to provide Veterans with the best possible medical care along with high satisfaction. If we can be of further assistance, please do not hesitate to contact us. Thank you.

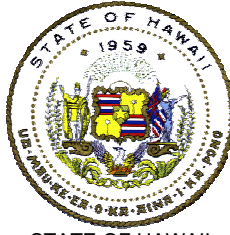
Sincerely,

A handwritten signature in dark ink, appearing to read "Suzanne M. Klinker".

SUZANNE M. KLINKER
Medical Center Director

APPENDIX M

LINDA LINGLE
GOVERNOR



STATE OF HAWAII
NARCOTICS ENFORCEMENT DIVISION
DEPARTMENT OF PUBLIC SAFETY
3375 Koapaka Street, Suite D-100
Honolulu, Hawaii 96819

CLAYTON A. FRANK
DIRECTOR

DAVID F. FESTERLING
Deputy Director of
Administration

TOMMY JOHNSON
Deputy Director
Corrections

JAMES L. PROPOTNICK
Deputy Director
Law Enforcement

No. _____

Patient Information for the Authorized Medical Use of Marijuana

HOW MUCH MARIJUANA AM I AUTHORIZED TO GROW OR POSSESS?

Permissible amounts of medical marijuana. (a) A qualifying patient who possesses a registry identification certificate issued pursuant to section 329-123, Hawaii Revised Statutes, may engage in and a registered primary caregiver of the patient may assist in, the medical use of marijuana only as justified to mitigate the symptoms or effects of the qualifying patient's debilitating medical condition.

(b) The medical marijuana shall be grown only at the following locations:

- (1) The qualifying patient's home address; or
- (2) The primary caregiver's home address or other location owned or controlled by the qualifying patient or the primary caregiver that is approved by the administrator and designated on the registry certificate issued by the department.

(c) The qualifying patient and primary caregiver jointly may not possess more than an "adequate supply" which shall not exceed a total of three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

(d) If any individuals described in subsection (a) possess, deliver, or produce marijuana in excess of the amounts allowed in subsection (c), such individuals are not exempted from the criminal laws of the State and shall be in violation of section 329-128(b) Hawaii Revised Statutes.

NOTE: Title 23 Chapter 202-2 Hawaii Administrative Rules states that the qualifying patient and primary caregiver jointly may not possess more than an "adequate supply" which shall not exceed a total of three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

In the case of qualifying patient cohabitating with other qualifying patient, it is recommended that all marijuana plants shall be clearly marked utilizing the qualifying patients medical marijuana registration number to assist in the identification of authorized plants to law enforcement. This is

also recommended for marijuana plants grown on property not next to a residence where an address can be verified.

PROHIBITED AREAS AND ACTIVITIES

The authorization for the medical use of marijuana shall **NOT** apply to:

- (1) The medical use of marijuana that endangers the health or well-being of another person;
- (2) The medical use of marijuana:
 - (A) In a school bus, public bus, or any moving vehicle;
 - (B) In the workplace of one's employment;
 - (C) On any school grounds;
 - (D) At any public park, public beach, public recreation center, recreation or youth center; or
 - (E) Any other place generally accessible to the public;
- (3) Any sale of marijuana; or
- (4) The use of marijuana by a qualifying patient, parent, or primary caregiver for purposes other than medical use permitted by this chapter.

In addition, although Hawaii law authorizes the medical use of marijuana, it does not authorize the distribution of marijuana (Dispensaries) other than the transfer from a qualifying patient's primary caregiver to the qualifying patient. Section 329-121, HRS (definition of "medical use"). State law provides no immunity from prosecution for any distribution of marijuana other than from the primary caregiver (defined in Section 329-121, HRS) to a qualifying patient ("a person who has been diagnosed by a physician as having a debilitating medical condition").

AMENDING INFORMATION ON MY REGISTRY IDENTIFICATION CERTIFICATE

Qualifying patients and primary caregivers are required to report any change in information submitted to the department on their written certification/registry identification application forms within five working days. A qualifying patient shall have only one primary caregiver and only one physician issuing a written certificate at any given time.

MODIFICATION, TRANSFER, AND TERMINATION OF CERTIFICATE

(a) In the event of a change of name or address of the qualifying patient, primary caregiver, or location where the qualifying patient elects to grow the qualifying patient's medical marijuana, the qualifying patient shall submit a letter with the updated information to the Department of Public Safety, Narcotics Enforcement Division, at 3375 Koapaka Street, Suite D-100, Honolulu, Hawaii 96819. The notification shall be submitted to the department within five working days of the change. No fee shall be assessed for the modification of the certificate.

(b) Failure to report a change of any of the information mentioned in subsection (a) shall invalidate the certificate as of the date of the change plus five working days and shall require re-registration and the imposition of a \$10 late fee.

(c) No certificate issued to a qualifying patient shall be assigned or otherwise transferred to any other patient.

(d) A qualifying patient who possesses a registry identification certificate who no longer suffers from a debilitating medical condition shall return the registry identification certificate to the department within seven calendar days of notification of the diagnosis. The qualifying patient's primary caregiver shall also return the issued registry identification certificate within the same period of time and the qualifying patient's medical marijuana supply disposed of in accordance with procedures set forth by the department.

(e) The qualifying patient's attending physician shall notify the department that the qualifying patient's condition no longer warrants the use of marijuana for medical purposes. The physician shall notify the qualifying patient of the contact.

(f) A certificate issued to a qualifying patient or primary caregiver is void upon the qualifying patient's death or if the patient's primary physician revokes the qualifying patient's written certificate. The qualifying patient's family, legal guardian, or primary caregiver shall notify the department within seven calendar days of the qualifying patient's death or revocation of the written certificate by the primary physician. The certificate shall be returned to the department and the qualifying patient's medical marijuana supply shall be disposed of in accordance with the procedures set forth by the department.

Revocation of registry identification certificate. (a) The department has the authority to revoke a registry identification certificate, with suspension of the registry identification certificate pending administrative hearing on the revocation. The department under one or more of the following conditions may revoke a registry identification certificate:

- (1) The applicant or physician has furnished false or fraudulent material information or omitted information in any of the written certification/registry forms submitted to the department under this chapter;
- (2) The written certificate issued to the qualifying patient was not based upon provisions set forth in section 329-126, Hawaii Revised Statutes;
- (3) Suspension or revocation of a physician's medical license or state controlled substance registration as designated under section 329-32, Hawaii Revised Statutes; or
- (4) For violations of section 23-202-3, 23-202-7, 23-202-13 or 23-202-14 Administrative Rules.

(b) When the department proposes to revoke a registration certificate of a qualifying patient or a designated primary caregiver, the department shall send a notice of proposed revocation by mail to the patient's address currently listed in the data file and a copy to the qualifying patient's primary caregiver and physician.

(c) A qualifying patient or designated primary caregiver may contest the proposed revocation of registration by submitting a request in writing within thirty days of the revocation for an administrative hearing in conformity with Chapter 91, Hawaii Revised Statutes. The request for hearing shall be addressed to: Narcotics Enforcement Division, Department of Public Safety, 3375 Koapaka Street, Suite D-100, Honolulu, HI 96819.

(d) The department may reinstate a registration certificate without reapplication.

Fraudulent misrepresentation; penalty. (a) Notwithstanding any law to the contrary, fraudulent misrepresentation to a law enforcement official of any fact or circumstance

relating to the medical use of marijuana to avoid arrest or prosecution under this part or Chapter 712, shall be a petty misdemeanor and subject to a fine of \$500.

WILL HAVING A PATIENT REGISTRY CERTIFICATE FOR THE MEDICAL USE OF MARIJUANA EXEMPT ME FROM U.S. DEPARTMENT OF TRANSPORTATION DRUG TESTING RULES?

No, employees who test positive for marijuana on a drug test, which is required under U.S. Department of Transportation (DOT) rules, will be reported positive whether or not an employee has a certificate issued by the State to utilize marijuana for medical purposes.

WILL THE DRUG TEST BE DECLARED NEGATIVE BECAUSE THE EMPLOYEE HAS A MEDICAL REASON FOR THE POSITIVE TEST RESULT?

If you are drug tested under a program required by the U.S. Department of Transportation (DOT), you will be deemed to have a positive test result even if you have followed all the medical marijuana requirements found in State rules. In addition, your employer will be required under DOT rules to remove you from safety-sensitive functions. The DOT rules do not recognize medical marijuana as a medical explanation for a positive test result. Therefore, the test will be declared positive by the MRO. Other federal agencies and other employers, at their own discretion, may elect to take a similar position. Your employer may also elect to other actions, including termination. It is, therefore, imperative that you talk to your employer relating to the possible consequences of utilizing marijuana for medical purposes in regards to drug testing.

What Hawaii's Medical Use of Marijuana Law Does NOT Do

Does Not Legalize Marijuana

State and Federal laws banning marijuana remain in effect and Hawaii's Medical Use of Marijuana Program does not permit the recreational use of marijuana.

Does Not Allow Just Anyone To Claim "Medical Use" of Marijuana

To be covered under Hawaii's medical marijuana law, a patient must have one of the listed debilitating medical conditions certified by his/her doctor, and registered with the Department and issued a Medical Marijuana Registry Patient Identification Certificate. If a patient is not registered with the Department then he is not qualified under this program.

Does Not Allow Unlimited Supplies of Medical Marijuana

Even patients who qualify under the law must still adhere to strict limits on the quantity of medical marijuana they possess. This is limited to an "adequate supply" which shall not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

Does Not Permit the Sale of Marijuana

The medical marijuana act defense will not protect someone who sells any amount of marijuana. Any evidence of sale of marijuana can result in prosecution and years of prison time, regardless of the buyers or seller's medical condition or medical

authorization to use marijuana.

Does not allow for marijuana dispensaries

Hawaii law does not authorize any person or entity to sell or dispense marijuana to medical use of marijuana patients. Hawaii law authorizes the medical use of marijuana, it does not authorize the distribution of marijuana (Dispensaries) other than the transfer from a qualifying patient's primary caregiver to the qualifying patient. Section 329-121, HRS (definition of "medical use"). State law provides no immunity from prosecution for any distribution of marijuana other than from the primary caregiver (defined in Section 329-121, HRS) to a qualifying patient ("a person who has been diagnosed by a physician as having a debilitating medical condition").

Does Not Allow the Use of Medical Marijuana in a Public Place, Workplace or in a Moving Vehicle

Even with a doctor's certification, the Act specifically prohibits use of medical marijuana in any bus or moving vehicle, in the workplace, on school grounds, any use that endangers the health or well being of another person, or in any public place.

Does Not Force a Doctor to Give a Certification for Medical Marijuana

No doctor is required to authorize the medical use of marijuana. Even patients who qualify under the law must still adhere to strict limits on the quantity of medical marijuana they possess.

Frequently Asked Questions

Q) Can the Department give me a list of physicians who are participating in the medical use of marijuana program? No State agencies are prohibited from recommending or referring a patient to particular physicians.

Q) Can I get copies of the application form to take to my physician? No, All medical use of marijuana application forms are issued directly to physicians participating in the program. All potential patients that have a debilitating medical condition that is authorized under the program should visit their treating physician who will do a medical examination and determine if that patient qualifies under the program. The authorization to use marijuana for medical purposes is the physician's decision and therefore application forms are limited to physicians participating in the program and not issued to the public for diversion reasons.

Q) What if I Have a Medical Condition Covered by the Medical Marijuana Act but Don't Have a Statement from My Doctor?

You do not receive the protections of the Act unless you have followed its requirements and procedures and obtained a certification from your physician.

Q) What If My Doctor Isn't Willing To Give Me a Certification or Says I Don't Qualify?

The Act does not force physicians to participate in the program it is up to the physician to use his / her best medical judgment in deciding to recommend marijuana for medical use. If a physician informs a patient that he does not qualify under the program then he

possibly does not have a debilitating medical condition as defined under the program or the physician feels that the risk associated with marijuana is not warranted.

Q) If My Doctor Wants More Information on the Medical Uses of Marijuana Where Can He/She Get It?

All physicians can obtain information from the Narcotics Enforcement Division by calling (808) 837-8470 or download information from the Division's webpage located at http://www.hawaii.gov/psd/ned_home.php.

Q) How Long Does My Doctor's Certification Last?

The certification lasts for one year from the time of the physician's signing for both patients and primary caregivers. After one year, the doctor must re-certify the patient.

Q) Does The Narcotics Enforcement Division Require a Registration Fee?

Yes, there is an annual registration fee of \$25 which covers the cost of the patient and if he has a primary caregiver. There is a charge of \$10 for a duplicate registration certificate and a \$15 bounced check penalty (All bounced checks will immediately invalidate the patient's medical use of marijuana certificate). It is recommended that the use of cashiers check or money order be utilized to avoid any processing problems.

Q) Can My Physician Assistant or Family Nurse Practitioner Authorize Medical Use of Marijuana?

No, Physician Assistants and Nurse Practitioners are not covered by the Hawaii's medical marijuana act. The only people who can authorize medical marijuana for a patient in Hawaii are physicians licensed by the state of Hawaii's (MD) and how have a active State Controlled Substance Registration.

Q) Why Can't I Get Medical Marijuana at a Pharmacy?

Marijuana is a Schedule I controlled Substance under both State and Federal law and not approved by the FDA and cannot be administered, prescribed or dispensed by a physician or pharmacy.

Q) Where Can I Obtain Medical Marijuana?

State law is silent on how a patient obtains his / her marijuana. The State does not authorize marijuana buyers clubs or recognize any legal source for marijuana to be utilized for medicinal purposes. The Hawaii's law states, however, that the "acquisition, possession, cultivation, use, distribution (defined as only the transfer of marijuana and paraphernalia from the primary caregiver to the qualifying patient), or transportation of marijuana" for medicinal use is specifically protected.

Q) What If My Condition or Illness Is Not Covered by Hawaii's Law?

Then you are ineligible for this program, however Hawaii's medical use of marijuana law provides that the state Department of Health set up a procedure for physicians and potentially qualifying patients to request that other medical conditions and diseases be added to the list of those debilitating medical conditions currently covered in the Act.

Q) What Is the Definition of "Mature" or "Usable" as It Relates to the Amount of Marijuana a Patient or Caregiver Is Allowed To Possess?

Under Title 23 Chapter 202 "mature plant" is defined as a marijuana plant whether male

or female, that has flowered and which have buds that are readily observed to the naked eye.

Q) Is My Use of Medical Marijuana Covered by Insurance?

No. The Act explicitly states that insurance companies are not required to pay for medical marijuana.

Q) Is a Patient's Confidentiality Protected?

Yes. However, upon an inquiry by a law enforcement agency, the Department of Public Safety will verify whether a particular qualifying patient has registered with the Department and may provide reasonable access to the registry information for official law enforcement purposes.

Q) Why Is Getting the Registration Card Important?

The registration card is evidence of compliance with the law and should ordinarily prevent an arrest. Without the card, the patient or caregiver may be arrested and held under arrest until the patient's right to use medical marijuana is confirmed.

Q) What Should a Patient Do If Stopped by the Police and Accused of Possession of Marijuana?

Politely show the officer your medical use of marijuana patient registry card. They may then contact the Narcotics Enforcement Division to verify your registration and let you go on your way.

Q) Can Minors Use Cannabis Under Hawai'i's Act?

Yes, Minors under 18 are protected under Hawai'i's law if their physician has explained the potential risks and benefits to both the qualifying patient and to their parent or legal guardian, and if the parent or legal guardian has consented in writing to allow the use; to serve as the minor's caregiver; and to control the minor's acquisition, dosage and frequency of use of the marijuana. A parent or guardian must serve as the minor's primary caregiver and follow the certification and registration procedures outlined above.

Q) What Should I Tell My Employer If I Am Subjected to a Drug Test?

The Act prohibits use of medical marijuana in the workplace but is silent regarding the employer's rights and duties regarding medical marijuana.

Q) Can Patients Living in Rental Units or Federally Subsidized Housing Participate in The Program?

As noted earlier, despite Hawaii's medical marijuana act, federal law or federal rules and regulations still prohibit the use, possession, cultivation, or distribution of marijuana. Any federal laws or rules prohibiting the use of marijuana in federally subsidized housing would likely come before Hawai'i's law. Patients occupying rental units or federally subsidized housing that wish to use medical marijuana should seek legal guidance on this issue.

Q) Are There Any Limits on Where Marijuana To Be Used for Medical Purposes Can Be Cultivated?

Title 23, Chapter 202-13 Hawaii Administrative Rules states that a patient's medical marijuana shall only be grown at the following locations:

- (1) The qualifying patient's home address;
- (2) The primary caregiver's home address; or
- (3) A location owned or controlled by the qualifying patient or the primary caregiver that is approved by the administrator of the Narcotics Enforcement Division and designated on the registry certificate issued by the department."

Q) Am I Covered under the Hawaii Medical Marijuana Law if I have a Medical Marijuana Certificate from another State?

No, Hawaii Law does not recognize medical use of marijuana certificates from other States. All Medical Use of Marijuana Certificates must be processed through a Physician licensed in the State of Hawaii with an active Controlled Substance Registration.

Act Can I Use Medical Marijuana in Other States?

At this time there are no arrangements with other states to honor the Hawaii law. Likewise Hawaii's does not recognize medical marijuana certification from other states such as Washington and California. The Hawaii medical marijuana act is only recognized within Hawaii.

APPENDIX N

Search Site

Sheriff Division



Pier 20
 Honolulu, Hawaii 96817
 Phone: 587-3621

Airport Unit - 24 hour dispatch	(808) 836 - 6606
Circuit Court	(808) 539 - 4599
Capitol - 24 hour dispatch	(808) 586 - 1352
Hawaii Section	(808) 933 - 8833
Kauai Section	(808) 482 - 2470
Maui Section	(808) 244 - 2900

The Sheriff Division carries out law enforcement services statewide. Its mission is to preserve the peace persons and property within premises under the control of the Judiciary and all State facilities; providing and execution of court documents; handling detained persons; and providing secure transportation for p It also provides law enforcement services at the Honolulu International Airport.

Sheriffs are involved at various stages of the criminal justice system. At the initial stage, they arrest, boc persons entering the system. At the police cellblock, they secure, escort and transport detainees. They t transport juvenile and adult inmates to inter-island and intra-state destinations for court appearances.

They serve various types of arrest warrants and other documents, and execute writs of possession. Dep conduct criminal and civil investigations on cases that occur within the jurisdiction of State entities. They records verification and background checks.

The Division is the lead agency of the State Law Enforcement Coalition, which was formed to meet the r federal Homeland Security Act. The coalition implements federal guidelines on issues related to weapon destruction.

With the heightened call for the security of waterways and harbors, the Division has been assisting the I Transportation Harbors Division with security and law enforcement functions. Additionally, through its sp unit, the Division is responsible for detecting narcotics and explosives in agencies within the Judiciary, tl correctional facilities, and other state and county agencies that request those services.

Sheriffs also provide security services to the Maui Memorial Hospital, Hawaii State Hospital, Waimano T Hospital, and Fort Ruger at the Department of Defense. They provide executive protection services to the Lieutenant Governor and, when requested, national and international dignitaries.

Although the functions and duties of deputy sheriffs vary in scope and nature, all Sheriff Division staff work with other federal, state, and county law enforcement agencies to provide for the health, safety and welfare of the State of Hawaii.

APPENDIX O

Narcotics Enforcement Division

3375 Koapaka Street, Suite D-100
Honolulu, Hawaii 96819
Phone: 837-8470
Fax: 837-8474

The Narcotics Enforcement Division (NED) is a statewide law enforcement agency that serves and protects by enforcing State laws pertaining to controlled substances and regulated chemicals. They are responsible for the manufacture, distribution, prescription, and dispensing of controlled substances and pharmaceuticals within the State.

NED is also responsible for assuring that pharmaceutical controlled substances are used for legitimate medical purposes. They register and investigate all violations of persons who administer, prescribe, manufacture or dispense controlled substances in the State, including those who work at methadone clinics.

NED enforces the requirements of the Uniform Controlled Substances Act (Chapter 329, Hawaii Revised Statutes) and the Medical Use of Marijuana Act (Chapter 329, Part IX, Hawaii Revised Statutes and Title 23, Chapter 200, Hawaii Administrative Rules). NED works extensively with county police departments and Federal agencies in detecting and prosecuting controlled substance and regulated chemical violators. In addition to enforcement, the Division focuses on education, diversion and prevention activities. The Division is also responsible for Hawaii's Electronic Prescription System (e-Pass) which monitors all Schedule II through V controlled substance prescriptions filled in the State.

- Application for Controlled Substances
- Physician's Assistant Application for Controlled Substances
- Medical Marijuana Patient Information
- Medical Marijuana Physicians Guidelines Form A
- Emergency Scheduling of Salvia Divinorum

APPENDIX P

AIRPORT POLICE SERVICES POLICY AND PROCEDURE	NUMBER: 5.03	PAGES: 1 of 3
	RELATED ORDERS: General Order 16.12	
	ISSUED DATE: December 11, 2007	
	REVIEW DATE:	
REVISION DATE:		
CHAPTER: Law Enforcement Operations	SUBJECT: Medical Marijuana at the Oakland International Airport Checkpoints	

- I. **PURPOSE:** To establish uniform procedures as it applies to individuals found to be in possession of or transporting marijuana into the Oakland International Airport or onto an aircraft, with or without the "medical marijuana" exception as defined in H&S Code sections 11362.5 and 11362.7 et seq.
- II. **POLICY:** It is the policy of the Airport Police Services to recognize the provisions allowed under California Health and Safety Code sections 11362.5 and 11362.7 et seq as well as to uniformly enforce California State Law-Health and Safety Code 11357(b), 11357(c), 11359 and 11360.
- III. **DEFINITIONS:**
- A. California Health and Safety Code 11362.5 is defined as the Compassionate Use Act of 1996. The purposes include:
1. To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of a serious medical condition such as cancer, AIDS, anorexia, chronic pain, etc. or any other illness for which marijuana provides relief.
 2. To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution. Less than eight (8) ounces in the possession of a qualified patient or primary caregiver who has received an oral or written recommendation or approval from a physician for the marijuana, regardless of whether or not they have or are carrying a "medical marijuana card," is allowed under the Compassionate Use Act and may be legally used and transported in California.
- B. **Attending Physician**-an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient and who has conducted a medical examination of that patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of marijuana is appropriate. H&S 11362.7(a)

- C. **Qualified Patient**-a person who is entitled to the protections of H&S Section 11362.5, who does not necessarily possess a medical marijuana card but who possesses no more than eight ounces of dried marijuana or has a doctor's recommendation for an amount consistent with the patient's needs. H&S 11362.7(f); H&S 11362.71(f), H&S 11362.77
- D. **Identification Card**-An official document issued by a California county health department that identifies a person authorized to engage in the medical use of marijuana and the identity of that person's designated primary caregiver, if any. H&S 11362.71
- E. **Person with an identification card**-an individual who is a qualified patient who has applied for and received a valid identification card.
- F. **Primary Caregiver**-the individual designated by a qualified patient or by a person with an identification card, who has consistently assumed responsibility for the housing, health, or safety of that patient or person. A primary caregiver must be at least 18 years of age. H&S 11362.5(e) and 11362.7(d)(e)
- G. **Serious Medical Condition**-AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraines, muscle spasms, seizures or any other chronic or persistent medical symptom. H&S 11362.5(b)(A); H&S 11362.7(h)
- H. **California Health and Safety Code 11357(b)**-Possession of less than an ounce of marijuana.
- I. **California Health and Safety Code 11357(o)**-Possession of more than an ounce of marijuana.
- J. **California Health and Safety Code 11359**-Possession of marijuana for sale.
- K. **California Health and Safety code 11360**-Transportation of marijuana for sale.

IV. PROCEDURE:

- A. Deputies will respond to all requests by Transportation Security Administration employees who have identified passengers found to be in possession of suspected marijuana at the checkpoints located inside of Terminals 1 & 2.
 1. Deputies will investigate and determine if the passenger found in possession of the suspected marijuana is a qualified patient or a primary caregiver as defined in H&S Code 11362.5 and 11362.7. If the passenger is deemed to be a qualified patient or primary caregiver and there are no other extenuating circumstances such as evidence of sales, the suspected marijuana will then be recognized as medical marijuana. If the medical marijuana is found to be eight (8) ounces or less, the passenger will be allowed to keep their medical marijuana and continue through the screening process and board their respective aircraft.
 2. If it is determined through the Deputy's investigation the passenger found in possession of suspected marijuana is not a qualified patient or primary caregiver as

Airport Police Services
Policy and Procedure

Page 3 of 3

defined in H&S Code sections 11362.5 and 11362.7, the person will be detained for a criminal investigation.

3. If the criminal investigation reveals violations of H&S 11357(b), 11357(c), 11359 or 11360, the passenger will be issued the appropriate citation and/or arrested.
4. The suspected marijuana will be processed according to General Order 16.12: Property/Evidence for Agency Use.

Client Identifier: AVIATION REGS
Database: CFR
Citation Text: 14 CFR s 91.19
Lines: 41
Documents: 1
Images: 0

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Westlaw

14 C.F.R. § 91.19

C

Effective: [See Text Amendments]

Code of Federal Regulations Currentness

Title 14, Aeronautics and Space

Chapter I, Federal Aviation Administration, Department of Transportation

Subchapter P, Air Traffic and General Operating Rules

Part 91, General Operating and Flight Rules (Refs & Annos)

Subpart A, General (Refs & Annos)

→ § 91.19 Carriage of narcotic drugs, marijuana, and depressant or stimulant drugs or substances.

(a) Except as provided in paragraph (b) of this section, no person may operate a civil aircraft within the United States with knowledge that narcotic drugs, marijuana, and depressant or stimulant drugs or substances as defined in Federal or State statutes are carried in the aircraft.

(b) Paragraph (a) of this section does not apply to any carriage of narcotic drugs, marijuana, and depressant or stimulant drugs or substances authorized by or under any Federal or State statute or by any Federal or State agency.

SOURCE: 54 FR 34292, Aug. 18, 1989; 56 FR 23178, May 20, 1991; 56 FR 48657, Sept. 25, 1991; 56 FR 65657, Dec. 17, 1991; 59 FR 32057, June 21, 1994; Amdt. 91-245, 60 FR 65913, Dec. 20, 1995; Amdt. 91-246, 60 FR 67255, Dec. 28, 1995; Amdt. 91-249, 61 FR 7190, Feb. 26, 1996; Amdt. 21- 88, 71 FR 52259, Sept. 1, 2006, unless otherwise noted.

AUTHORITY: 49 U.S.C. 106(a), 1155, 40103, 40113, 40120, 44101, 44111, 44701, 44704, 44709, 44711, 44712, 44715, 44716, 44717, 44722, 46306, 46315, 46316, 46504, 46506-46507, 47122, 47508, 47528-47531, articles 12 and 29 of the Convention on International Civil Aviation (61 Stat. 1180).

14 C. F. R. § 91.19, 14 CFR § 91.19

Airport TSAs allow local law to rule the skies

By Mickey Martin

Cannabis patients can travel with their medicine if they are within the bounds of state and local laws of the airport in which they are traveling, according to the Transportation Security Admin. (TSA).

With the help of attorney Rob Raich, Oakland International Airport crafted a written policy in 2008 stating that they would not arrest patients or confiscate their medicines if they were within the legal bounds of the state's medical marijuana laws. The *West Coast Leaf* first reported this story in September, which was then picked up by local and national media outlets. Upon further questioning, TSA spokeswoman Suzanne Trevino confirmed that the federal agency would allow patients to travel with cannabis if the local authorities deemed it appropriate.

Airport officials in Los Angeles, San Francisco, San Jose, and Sacramento confirmed that they had no interest in confiscating legitimate cannabis medicines or arresting legitimate users. Patients can now travel from these airports without fear of losing their medicine or facing arrest.

This landmark realization comes on the heels of the new federal policy curbing federal interference into state medical cannabis affairs. It is a major victory for patients who in the past have been forced to travel without their medicine or forced to purchase cannabis at their destination from often-illicit sources.

"It's clearly a good thing that airports such as Oakland and SFO allow patients to be able to travel with their medicine. That's a positive policy," Americans for Safe Access spokesperson Kris Hermes said. "Some patients cannot be without their medicine for more than a few hours."

While tolerance at some California airports is a welcome relief to many patients, it is still a far cry from complete tolerance.

Patients can still be subject to prosecution at their final destination or at airports in jurisdictions where local law enforcement chooses to ignore state law, such as Burbank and San Diego. Even with enforcement policies left to local authorities as stated by the TSA, this can still create confusion for patients, as policies will differ from city to city

and airport to airport. Patients look forward to having a statewide or federal policy in place with clear protections for patients choosing to travel with cannabis.

As patients, activists, and concerned citizens continue to demand clarification, it is possible that state boundaries for medical cannabis will become the standard by which federal agencies, such as TSA, abide. It is possible this policy could evolve to other agencies such as US Postal Inspectors or National Park Service agencies.

While patients can feel a bit safer in their travels, it is important to understand that they must still be discreet and not flaunt their cannabis in the face of what could be less tolerant authorities. Attorney Rob Raich suggests not declaring one's medicine unless asked. Individual officers and their agencies may still choose to ignore state laws and hassle qualified patients who possess their cannabis while traveling. It is best to inquire about the policy of the airport in which one hopes to travel before showing up and meeting unexpected resistance.

Oregon initiative moving

Continued from page 3

are drafting proposed rules, including a program similar to food stamps that needy patients could use at any dispensary.

The initiative also allows DHS to conduct research that could result in quality control standards for commercial medical cannabis. These could be used to regulate product uniformity, prohibit dangerous contaminants, and provide content labels for THC, CBD and other ingredients.

If Voter Power prevails, Oregon voters will decide the initiative's fate in the November general election. Polls show 59 percent of Oregonians support the measure, with just 32 percent opposed.

For more info, see voterpower.org.

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APPENDIX Q

LINDA LINGLE
GOVERNOR



STATE OF HAWAII
NARCOTICS ENFORCEMENT DIVISION
DEPARTMENT OF PUBLIC SAFETY
3375 Koaapaka Street, Suite D-100
Honolulu, Hawaii 96819

FRANK J. LOPEZ
INTERIM DIRECTOR

CLAIRE Y. NAKAMURA
Deputy Director
Administration

Deputy Director
Corrections

JAMES L. PROPOTNICK
Deputy Director
Law Enforcement

No. _____

December 9, 2005

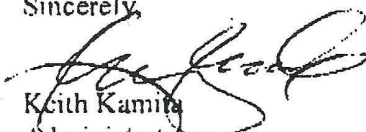
To the patients of Dr. William Wenner:

Due to the passing of Dr. William Wenner on November 24, 2005, all of the Medical Use of Marijuana Certificates issued by Dr. Wenner are no longer valid. All patients will be given till February 1, 2006, to find a new treating physician. Patients are to have their new treating physician fill out another medical use of marijuana application and submit it to the Narcotics Enforcement Division. If your existing registration is still current there will be no charge assessed to change the name of your treating physician. Your new certificate will have the same expiration date as your existing one.

NOTE: The Narcotics Enforcement Division is not authorized to issue a list or recommend the names of physicians participating in the Medical Use of Marijuana Program. Please contact a local physician for a referral.

If you have any questions regarding this matter please contact the Narcotics Enforcement Division Registration Section at (808) 837-8470.

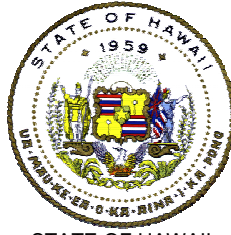
Sincerely,



Keith Kamita
Administrator

APPENDIX R

LINDA LINGLE
GOVERNOR



STATE OF HAWAII
NARCOTICS ENFORCEMENT DIVISION
DEPARTMENT OF PUBLIC SAFETY
3375 Koapaka Street, Suite D-100
Honolulu, Hawaii 96819

CLAYTON A. FRANK
DIRECTOR

DAVID F. FESTERLING
Deputy Director of
Administration

TOMMY JOHNSON
Deputy Director
Corrections

JAMES L. PROPOTNICK
Deputy Director
Law Enforcement

No. _____

Physician's Guideline for Completing Hawaii's Written Certification / Registry Identification Forms for the Medical Use of Marijuana

All physicians wishing to recommend marijuana for medical purposes must be licensed under Chapters 453 and 460, Hawaii Revised Statutes, and licensed with authority to prescribe drugs and is registered under section 329-32, Hawaii Revised Statutes. The term "Physician" does not include Physician's Assistant as described in Section 453-5.3, Hawaii Revised Statutes. Chapter 329-32 requires that the location where the practitioner will be treating patients and recommending that patient to utilize marijuana for medical purposes be listed in that physician's State controlled substance registration information.

Physicians who authorize their patients to utilize marijuana for medical purposes shall submit the completed qualifying patient and primary caregiver written certification / registry identification forms and \$25 registration fee to:

Narcotics Enforcement Division
3375 Koapaka Street, Suite D-100
Honolulu, Hawaii 96819

The issued registry certificate card signed by the qualifying patients physician and NED Administrator along with the completed written certification / registry identification application forms shall serve as the physician's written certification. This certification shall be based upon the physician's professional opinion after having completed a full face to face assessment of the patient to include a review of patient's medical history and current medical condition made in the course of a bona fide physician-patient relationship that the qualifying patient has been diagnosed with a debilitating medical condition; and that the physician has certified that in the physician's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient. No person shall engage in the use of marijuana for medical purposes until they have completed the written certification / registry identification application forms with their physician, paid the required registration fees and is issued a signed registry certificate from his / her physician. Upon receipt of the completed written certification / registry identification forms from the qualifying patient's physician the Department will verify the information provided, and mail the registry certificates for the patient and his/her primary caregiver, if any, to the requesting physician. **The physician shall sign and issue the registry certificates to his/her patient and the patient's primary caregiver, if any.**

Physicians wishing to recommend the medical use of marijuana for their qualifying patients shall fill out section C of the Written Certification / Registry Identification Forms (Registration Forms) and have their patient complete Section A, B, D and E. The patient and his primary caregiver, if any, shall provide a photocopy of their current Hawaii Driver's License, Hawaii State Identification Card or Passport with the completed registration form. A qualifying patient shall have only one primary caregiver and only one physician issuing a written certificate at any given time.

1. In the case of a patient who is under the age of eighteen years or an adult lacking legal capacity, the patient's parent, guardian, or person having legal custody shall fill out Section A, B, D and E of the registration form. The patient's parent, guardian, or person having legal custody shall act as the patient's primary caregiver.
2. All patients over the age of eighteen years that elect to have a primary caregiver must fill out Section D of the registration form. Every primary caregiver shall be responsible for the care of only one qualifying patient at any given time. The term "primary caregiver" means a person, other than the qualifying patient and the qualifying patient's physician, who is eighteen years of age or older, and who has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana. In the case of a minor or an adult lacking legal capacity, the primary caregiver shall be a parent, guardian, or person having legal custody.
3. A patient or their primary caregiver that elects to grow the authorized amount of marijuana for medical purposes shall fill out Section E of the registration form.

Permissible amounts of medical marijuana. (a) A qualifying patient who possesses a registry identification certificate issued pursuant to section 329-123, Hawaii Revised Statutes, may engage in and a registered primary caregiver of the patient may assist in, the medical use of marijuana only as justified to mitigate the symptoms or effects of the qualifying patient's debilitating medical condition.

(b) The medical marijuana shall be grown only at the following locations:

- (1) The qualifying patient's home address; or
- (2) The primary caregiver's home address or other location owned or controlled by the qualifying patient or the primary caregiver that is approved by the administrator and designated on the registry certificate issued by the department.

(c) The qualifying patient and primary caregiver jointly may not possess more than an "adequate supply" which shall not exceed a total of three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

(d) If any individuals described in subsection (a) possess, deliver, or produce marijuana in excess of the amounts allowed in subsection (c), such individuals are not exempted from the criminal laws of the State and shall be in violation of section 329-128(b) Hawaii Revised Statutes.

NOTE: Title 23 Chapter 202-2 Hawaii Administrative Rules states that the qualifying patient and primary caregiver jointly may not possess more than an “adequate supply” which shall not exceed a total of three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

In the case of qualifying patient cohabitating with other qualifying patient, it is recommended that all marijuana plants shall be clearly marked utilizing the qualifying patients medical marijuana registration number to assist in the identification of authorized plants to law enforcement. This is also recommended for marijuana plants grown on property not next to a residence where an address can be verified.

Section 329-1, Definitions

"Physician-patient relationship" means the collaborative relationship between physicians and their patients. To establish this relationship, the treating physician or the physician's designated member of the health care team, at a minimum shall:

- (1) Personally perform a face-to-face history and physical examination of the patient that is appropriate to the specialty training and experience of the physician or the designated member of the physician's health care team, make a diagnosis and formulate a therapeutic plan, or personally treat a specific injury or condition;
- (2) Discuss with the patient the diagnosis or treatment, including the benefits of other treatment options; and
- (3) Ensure the availability of appropriate follow-up care.

PROHIBITED AREAS AND ACTIVITIES

The authorization for the medical use of marijuana shall **NOT** apply to:

- (1) The medical use of marijuana that endangers the health or well-being of another person;
- (2) The medical use of marijuana:
 - (A) In a school bus, public bus, or any moving vehicle;
 - (B) In the workplace of one's employment;
 - (C) On any school grounds;
 - (D) At any public park, public beach, public recreation center, recreation or youth center; or
 - (E) Any other place generally accessible to the public;
- (3) Any sale of marijuana; or
- (4) The use of marijuana by a qualifying patient, parent, or primary caregiver for purposes other than medical use permitted by this chapter.

In addition, although Hawaii law authorizes the medical use of marijuana, it does not authorize the distribution of marijuana other than the transfer from a qualifying patient's primary caregiver to the qualifying patient. Section 329-121, HRS (definition of "medical use"). State law provides no immunity from prosecution for any distribution of marijuana other than from the primary caregiver (defined in

Section 329-121, HRS) to a qualifying patient ("a person who has been diagnosed by a physician as having a debilitating medical condition").

1. In order for the application to be complete, a registration fee of \$25 shall be paid at the time the written certification / registry identification forms are submitted to the Department. Payment shall be made in the form of a certified, or cashier's check or money order payable to the Narcotics Enforcement Division. Payment by a bank cashier's check, or money order will allow for faster processing. Payment made in the form of stamps, foreign currency, or third party endorsed checks will not be accepted. No refund will be issued once the written certification/registry identification forms have been received at the department.
2. All patients and their primary caregivers shall report any change in information required by the department within five working days. A qualifying patient shall have only one primary caregiver and only one physician issuing a written certificate at any given time.

NOTE: The registry identification certificate authorizes the possession, and use of marijuana for medical purposes under State law only. Federal law prohibits the possession, use or distribution of marijuana within the State and to locations outside the State.

Revocation of registry identification certificate. (a) The department has the authority to revoke a registry identification certificate, with suspension of the registry identification certificate pending administrative hearing on the revocation. The department under one or more of the following conditions may revoke a registry identification certificate:

- (1) The applicant or physician has furnished false or fraudulent material information or omitted information in any of the written certification/registry forms submitted to the department under this chapter;
 - (2) The written certificate issued to the qualifying patient was not based upon provisions set forth in section 329-126, Hawaii Revised Statutes;
 - (3) Suspension or revocation of a physician's medical license or state controlled substance registration as designated under section 329-32, Hawaii Revised Statutes; or
 - (4) For violations of section 23-202-3, 23-202-7, 23-202-13 or 23-202-14 Administrative Rules.
- (b) When the department proposes to revoke a registration certificate of a qualifying patient or a designated primary caregiver, the department shall send a notice of proposed revocation by mail to the patient's address currently listed in the data file and a copy to the qualifying patient's primary caregiver and physician.
- (c) A qualifying patient or designated primary caregiver may contest the proposed revocation of registration by submitting a request in writing within thirty days of the revocation for an administrative hearing in conformity with Chapter 91, Hawaii Revised

Statutes. The request for hearing shall be addressed to: Narcotics Enforcement Division, Department of Public Safety, 3375 Koapaka Street, Suite D-100, Honolulu, HI 96819.

(d) The department may reinstate a registration certificate without reapplication.

Fraudulent misrepresentation; penalty. (a) Notwithstanding any law to the contrary, fraudulent misrepresentation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution under this part or Chapter 712, shall be a petty misdemeanor and subject to a fine of \$500.

What Hawaii's Medical Use of Marijuana Law Does NOT Do

Does Not Legalize Marijuana

State and Federal laws banning marijuana remain in effect and Hawaii's Medical Use of Marijuana Program does not permit the recreational use of marijuana.

Does Not Allow Just Anyone To Claim 'Medical Use' of Marijuana

To be covered under Hawaii's medical marijuana law, a patient must have one of the listed debilitating medical conditions certified by his/her doctor, and registered with the Department and issued a Medical Marijuana Registry Patient Identification Certificate. If a patient is not registered with the Department then he is not qualified under this program.

Does Not Allow Unlimited Supplies of Medical Marijuana

Even patients who qualify under the law must still adhere to strict limits on the quantity of medical marijuana they possess. This is limited to an "adequate supply" which shall not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

Does Not Permit the Sale of Marijuana

The medical marijuana act defense will not protect someone who sells any amount of marijuana. Any evidence of sale of marijuana can result in prosecution and years of prison time, regardless of the buyers or seller's medical condition or medical authorization to use marijuana.

Does not allow for marijuana dispensaries

Hawaii law does not authorize any person or entity to sell or dispense marijuana to medical use of marijuana patients. Hawaii law authorizes the medical use of marijuana, it does not authorize the distribution of marijuana (Dispensaries) other than the transfer from a qualifying patient's primary caregiver to the qualifying patient. Section 329-121, HRS (definition of "medical use"). State law provides no immunity from prosecution for any distribution of marijuana other than from the primary caregiver (defined in Section 329-121, HRS) to a qualifying patient ("a person who has been diagnosed by a physician as having a debilitating medical condition").

Does Not Allow the Use of Medical Marijuana in a Public Place, Workplace or in a Moving Vehicle

Even with a doctor's certification, the Act specifically prohibits use of medical marijuana in any bus or moving vehicle, in the workplace, on school grounds, any use that endangers the health or well being of another person, or in any public place.

Does Not Force a Doctor to Give a Certification for Medical Marijuana

No doctor is required to authorize the medical use of marijuana.

Even patients who qualify under the law must still adhere to strict limits on the quantity of medical marijuana they possess.

Frequently Asked Questions

Q) Will having a patient registry certificate for the medical use of marijuana exempt the patient from u.s. department of transportation drug testing rules? No, employees who test positive for marijuana on a drug test, which is required under U.S. Department of Transportation (DOT) rules, will be reported positive whether or not an employee has a certificate issued by the State to utilize marijuana for medical purposes.

Q) Will the drug test be declared negative because the employee has a medical reason for the positive test result? If you are drug tested under a program required by the U.S. Department of Transportation (DOT), you will be deemed to have a positive test result even if you have followed all the medical marijuana requirements found in State rules. In addition, your employer will be required under DOT rules to remove you from safety-sensitive functions. The DOT rules do not recognize medical marijuana as a medical explanation for a positive test result. Therefore, the test will be declared positive by the MRO. Other federal agencies and other employers, at their own discretion, may elect to take a similar position. Your employer may also elect to other actions, including termination. It is, therefore, imperative that you talk to your employer relating to the possible consequences of utilizing marijuana for medical purposes in regards to drug testing.

Q) Can the Department give me a list of physicians who are participating in the medical use of marijuana program? No State agencies are prohibited from recommending or referring a patient to particular physicians.

Q) Can I get copies of the application form to take to my physician? No, All medical use of marijuana application forms are issued directly to physicians participating in the program. All potential patients that have a debilitating medical condition that is authorized under the program should visit their treating physician who will do a medical examination and determine if that patient qualifies under the program. The authorization to use marijuana for medical purposes is the physician's decision and therefore application forms are limited to physicians participating in the program and not issued to the public for diversion reasons.

Q) What if I Have a Medical Condition Covered by the Medical Marijuana Act but Don't Have a Statement from My Doctor?

You do not receive the protections of the Act unless you have followed its requirements and procedures and obtained a certification from your physician.

Q) What If My Doctor Isn't Willing To Give Me a Certification or Says I Don't Qualify?

The Act does not force physicians to participate in the program it is up to the physician to use his / her best medical judgment in deciding to recommend marijuana for medical use. If a physician informs a patient that he does not qualify under the program then he possibly does not have a debilitating medical condition as defined under the program or the physician feels that the risk associated with marijuana is not warranted.

Q) If My Doctor Wants More Information on the Medical Uses of Marijuana Where Can He/She Get It?

All physicians can obtain information from the Narcotics Enforcement Division by calling (808) 837-8470 or download information from the Division's webpage located at http://www.hawaii.gov/psd/ned_home.php .

Q) How Long Does My Doctor's Certification Last?

The certification lasts for one year from the time of the physician's signing for both patients and primary caregivers. After one year, the doctor must re-certify the patient.

Q) Does The Narcotics Enforcement Division Require a Registration Fee?

Yes, there is an annual registration fee of \$25 which covers the cost of the patient and if he has a primary caregiver. There is a charge of \$10 for a duplicate registration certificate and a \$15 bounced check penalty (All bounced checks will immediately invalidate the patient's medical use of marijuana certificate). It is recommended that the use of cashiers check or money order be utilized to avoid any processing problems.

Q) Can My Physician Assistant or Family Nurse Practitioner Authorize Medical Use of Marijuana?

No, Physician Assistants and Nurse Practitioners are not covered by the Hawaii's medical marijuana act. The only people who can authorize medical marijuana for a patient in Hawaii are physicians licensed by the state of Hawaii's (MD) and how have a active State Controlled Substance Registration.

Q) Why Can't I Get Medical Marijuana at a Pharmacy?

Marijuana is a Schedule I controlled Substance under both State and Federal law and not approved by the FDA and cannot be administered, prescribed or dispensed by a physician or pharmacy.

Q) Where Can I Obtain Medical Marijuana?

State law is silent on how a patient obtains his / her marijuana. The State does not authorize marijuana buyers clubs or recognize any legal source for marijuana to be utilized for medicinal purposes. The Hawaii's law states, however, that the "acquisition,

possession, cultivation, use, distribution (defined as only the transfer of marijuana and paraphernalia from the primary caregiver to the qualifying patient), or transportation of marijuana” for medicinal use is specifically protected.

Q) What If My Condition or Illness Is Not Covered by Hawaii’s Law?

Then you are ineligible for this program, however Hawaii’s medical use of marijuana law provides that the state Department of Health set up a procedure for physicians and potentially qualifying patients to request that other medical conditions and diseases be added to the list of those debilitating medical conditions currently covered in the Act.

Q) What Is the Definition of “Mature” or “Usable” as It Relates to the Amount of Marijuana a Patient or Caregiver Is Allowed To Possess?

Under Title 23 Chapter 202 “mature plant” is defined as a marijuana plant whether male or female, that has flowered and which have buds that are readily observed to the naked eye.

Q) Is My Use of Medical Marijuana Covered by Insurance?

No. The Act explicitly states that insurance companies are not required to pay for medical marijuana.

Q) Is a Patient’s Confidentiality Protected?

Yes. However, upon an inquiry by a law enforcement agency, the Department of Public Safety will verify whether a particular qualifying patient has registered with the Department and may provide reasonable access to the registry information for official law enforcement purposes.

Q) Why Is Getting the Registration Card Important?

The registration card is evidence of compliance with the law and should ordinarily prevent an arrest. Without the card, the patient or caregiver may be arrested and held under arrest until the patient’s right to use medical marijuana is confirmed.

Q) What Should a Patient Do If Stopped by the Police and Accused of Possession of Marijuana?

Politely show the officer your medical use of marijuana patient registry card. They may then contact the Narcotics Enforcement Division to verify your registration and let you go on your way.

Q) Can Minors Use Cannabis Under Hawai’i’s Act?

Yes, Minors under 18 are protected under Hawai’i’s law if their physician has explained the potential risks and benefits to both the qualifying patient and to their parent or legal guardian, and if the parent or legal guardian has consented in writing to allow the use; to serve as the minor’s caregiver; and to control the minor’s acquisition, dosage and frequency of use of the marijuana. A parent or guardian must serve as the minor’s primary caregiver and follow the certification and registration procedures outlined above.

Q) What Should I Tell My Employer If I Am Subjected to a Drug Test?

The Act prohibits use of medical marijuana in the workplace but is silent regarding the employer's rights and duties regarding medical marijuana.

Q) Can Patients Living in Rental Units or Federally Subsidized Housing Participate in The Program?

As noted earlier, despite Hawaii's medical marijuana act, federal law or federal rules and regulations still prohibit the use, possession, cultivation, or distribution of marijuana. Any federal laws or rules prohibiting the use of marijuana in federally subsidized housing would likely come before Hawai'i's law. Patients occupying rental units or federally subsidized housing that wish to use medical marijuana should seek legal guidance on this issue.

Q) Are There Any Limits on Where Marijuana To Be Used for Medical Purposes Can Be Cultivated?

Title 23, Chapter 202-13 Hawaii Administrative Rules states that a patient's medical marijuana shall only be grown at the following locations:

- (1) The qualifying patient's home address;
- (2) The primary caregiver's home address; or
- (3) A location owned or controlled by the qualifying patient or the primary caregiver that is approved by the administrator of the Narcotics Enforcement Division and designated on the registry certificate issued by the department."

Q) Am I Covered under the Hawaii Medical Marijuana Law if I have a Medical Marijuana Certificate from another State?

No, Hawaii Law does not recognize medical use of marijuana certificates from other States. All Medical Use of Marijuana Certificates must be processed through a Physician licensed in the State of Hawaii with an active Controlled Substance Registration.

Act Can I Use Medical Marijuana in Other States?

At this time there are no arrangements with other states to honor the Hawaii law. Likewise Hawaii's does not recognize medical marijuana certification from other states such as Washington and California. The Hawaii medical marijuana act is only recognized within Hawaii.