

TO: TOWN COUNCIL

FROM: TOWN MANAGER 

RE: CONSIDER WHETHER TO ALLOW MEDICAL MARIJUANA
DISPENSARIES IN THE TOWN OF LOOMIS

ISSUE

The Council is asked to consider whether to allow medical marijuana dispensaries in the Town.

RECOMMENDATION

Discuss and determine how Council wishes to proceed.

Following are options to consider:

1. DO NOTHING: The existing Town zoning regulations do not provide for the location and/or regulation of "dispensaries" and such uses might be permissible in any zone that allows retail uses, drug stores, or medical uses. Since there are no current regulations either, such uses might be established in areas that would conflict with the requirements of the General Plan, be inconsistent with surrounding uses, or be detrimental to the public health, safety and welfare. It is likely that in an environmental determination for locating such uses, Staff would recommend at a minimum that a negative declaration be prepared to analyze such things as traffic, proximity to schools, police impacts, and urban decay.
2. PROHIBIT USE: There is still an ongoing legal controversy between those states which permit medical use of marijuana and the Federal Government as a result of the Federal law which prohibits the use and/or possession of marijuana for any purposes. Locally the cities of Lincoln, Rocklin, Roseville prohibit medical marijuana dispensaries.
3. REGULATE USE: Establish zoning requirements and regulate such things as location, hours of operation, on site activities (e.g. no alcohol sales, age of people allowed on site, registering of employees and background checks, fees and charges. Regulating the use gives the Town a process by which a permit can be discontinued or modified if it becomes a public nuisance. It also gives the operator a process to appeal permitting and permit enforcement decisions. It is likely that regulations will require environmental review to analyze such factors

as traffic, proximity to schools, police impacts, and urban decay before being approved.

4. Continue under the moratorium in order to conduct one or more special meetings further study and decide
5. Convene a task force to study the issue and make a recommendation to the Council. A task force might consist of marijuana advocates, local doctors, educators, law enforcement and others that the Council may want to include.

CEQA

There are no CEQA issues at this time.

MONEY

Money issues are subject to Council action. In general, a YES to the use could result in additional sales tax and licensing revenue however that could be offset by additional police and enforcement services. A NO to the use would result in sales tax, licensing fees, police and enforcement services continuing as they are today. In taking either action a lawsuit could be filed by a disgruntled party and the Town could incur indeterminate costs for legal services. Other options may have other financial ramifications that will need to be determined based on the option chosen.

DISCUSSION

This matter is under consideration because the Town was asked to issue a business license for a medical marijuana dispensary (also known as medical cannabis dispensaries and henceforth in this report will be called "dispensaries"). Existing Town zoning regulations do not provide for the location and/or regulation of "dispensaries" and such uses might be permissible in any zone that allows retail uses, drug stores, or medical uses. If "dispensaries" were allowed to be established without appropriate regulation, such uses might be established in areas that would conflict with General Plan requirements, be inconsistent with surrounding uses, or be detrimental to the public health, safety and welfare.

If such uses were to proceed into the development review process under the current zoning regulations, such uses could conflict with, and defeat the purpose of studying and adopt regulations regarding medical marijuana dispensaries. On July 21, 2009 Council instituted a 45 day moratorium that Council extended for 10 months and 15 days on August 11, 2009 as allowed by law in order to have sufficient time, if needed, to study and rule on the issue.

Marijuana use, medicinally or otherwise, is a contentious public policy and legal issue. Marijuana use under Federal law is illegal. The Controlled Substances Act of 1970 categorizes marijuana as a schedule 1 drug (see attached description of Federal categories) that is illegal for any purpose. Schedule 1 drugs under the Act have the following characteristics:

- The drug or other substance has a high potential for abuse.
- The drug or other substance has no currently accepted medical use in treatment in the United States.
- There is a lack of accepted safety for use of the drug or other substance under medical supervision.

Under the Federal Controlled Substances Act, possession of any marijuana is a misdemeanor and cultivation is a felony. In addition, the premises used to sell or cultivate marijuana for sale are subject to forfeiture.

Federal law has not prevented a number of states, including California, from enacting medical marijuana legislation. These states include: Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont and Washington. Ten states have symbolic medical marijuana laws which are laws that support medical marijuana but do not provide patients with legal protection under state law.

In 1996, the voters of the State of California approved Proposition 215, the Compassionate Use Act of 1996, which took effect on November 6, 1996 as California Health & Safety Code section 11362.5. The vote locally was:

	YES	NO
Placer County	44,484 (47.9%)	48,466 (52.1%)
Loomis	1,200 (44.5%)	1,495 (55.5%)

The purposes of the Act are:

- 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 cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief. However, it is not enough to have one of these diseases to be automatically qualified for marijuana exemption under Proposition 215; a physician's recommendation is required.

- To encourage the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana.

In January 2004 SB 420, a legislative statute, went into effect as California Health and Safety Code section 11362.7 et.seq. This law broadens Proposition 215 to transportation and other offenses in certain circumstances: allows patients to "collectively or cooperatively" cultivate for medical purposes; allows probationers, parolees, and prisoners to apply for permission to use medical marijuana; and sets limits on where marijuana may be smoked. The law also establishes a statewide, voluntary ID card system administered by county health departments. This program is commonly referred to as the Medical Marijuana Program (MMP). Patients with ID cards are supposed to be protected from arrest provided they adhere to specified quantity limits. However, not all counties offer state ID cards at this point. The County of Sacramento implemented the MMP in January 2009. The MMP is supposed to provide patients who obtain and use marijuana for medical purposes or their primary caregivers obtain on their behalf, a legal defense (also known as an "affirmative defense") against unnecessary arrests and criminal sanctions. (See attached "Frequently Asked Questions" for more information.)

"Dispensaries" typically characterize themselves as "primary caregivers" to claim coverage under Proposition 215 and SB 420. However, these laws specifically define a primary caregiver as a person who consistently assumes the responsibility for the housing, health or safety of the patient. Being a primary caregiver is not simply providing marijuana for a patient's health; the responsibility for a patient's health must be consistent; it must be independent of merely providing marijuana for a qualified person; and such a primary caregiver-patient relationship must begin before or contemporaneously with the time of assumption of responsibility for assisting the individual with marijuana. [People vs. Mentch (2008) 45 Cal. 4th 274, 283] There are many dispensaries in California. (See attached list of dispensaries in the Sacramento area and the picture of two dispensary interiors.) The list in the attachments does not indicate the Colfax dispensary that has been operating for a number of years. Given the proximity of dispensaries to major hospitals in the area it would appear that individuals with serious illness, who

have been prescribed medical cannabis, will be able to find a dispensary in the greater Sacramento area. Of course, how convenient the dispensary location is depends on the circumstances of the individual requiring the service.

In August 2008 the California Attorney General issued a set of guidelines (see attached Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use.) for the purpose of:

- ensuring that marijuana grown for medical purposes remains secure and does not find its way to non-patients or illicit markets;
- helping law enforcement agencies perform their duties in accordance with California law; and
- helping patients and primary caregivers understand how they may cultivate, transport, possess, and use medical marijuana under California law.

For purposes of local regulation the Attorney General stated that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines are likely operating outside the law and are subject to arrest and criminal prosecution.

As an example, the Attorney General cited two dispensaries that merely require patients to complete a form summarily designating a business owner as their primary caregiver and then offering marijuana in exchange for cash "donations" are likely unlawful. Some commentators have indicated that in light of the restrictive and burdensome requirements set forth in the guidelines virtually all of the existing medical marijuana dispensaries operating in California are violating state law.

To further confuse the legal issue between federal and state law, U.S. Attorney General Eric H. Holder Jr. stated on March 18, 2009 that the Justice Department will not prosecute medical marijuana dispensaries that are operating legally under state laws in California and the twelve other states that have permitted the use of marijuana for medical purposes. On May 6, 2009, Governor Schwarzenegger called for a debate on legalizing marijuana.

CONCLUSION

One comment that came up at the August 2009 Council meeting was whether or not to conduct a community survey. A professional survey, similar to that done for the park element of the General Plan, could run \$18,000 to 25,000. An email survey could run under \$5,000. A mail survey could run less than \$2,000. Having one or more workshops may also give Council sufficient information to decide on the community will. There is also the option of putting this to a vote of the people.

ATTACHMENTS

- 5 pages Schedule of Drugs as described on the US Drug Enforcement Administration web site
- 3 pages List of Frequently Asked Questions -- provided by Giving Hope Patient Care Collective
- 4 pages Excerpt from a list of medical cannabis collectives showing collectives in the Sacramento area as noted in the CA Norml website (www.ca-norml.org)
- 1 page Pictures of the interior of two medical marijuana dispensaries
- 11 pages "Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use" by Attorney General Edmund G. Brown Jr. Department of Justice, State of California dated August 2008



Controlling Drugs or Other Substances

Formal Scheduling

The Controlled Substances Act (CSA) places all substances which were in some manner regulated under existing federal law into one of five schedules. This placement is based upon the substance's medical use, potential for abuse, and safety or dependence liability. The Act also provides a mechanism for substances to be controlled, or added to a schedule; decontrolled, or removed from control; and rescheduled or transferred from one schedule to another. The procedure for these actions is found in Section 201 of the Act (21 U.S.C. 811).

Proceedings to add, delete, or change the schedule of a drug or other substance may be initiated by the Drug Enforcement Administration (DEA), the Department of Health and Human Services (HHS), or by petition from any interested person: the manufacturer of a drug, a medical society or association, a pharmacy association, a public interest group concerned with drug abuse, a state or local government agency, or an individual citizen. When a petition is received by the DEA, the agency begins its own investigation of the drug.

The DEA also may begin an investigation of a drug at any time based upon information received from law enforcement laboratories, state and local law enforcement and regulatory agencies, or other sources of information.

Once the DEA has collected the necessary data, the DEA Administrator, by authority of the Attorney General, requests from HHS a scientific and medical evaluation and recommendation as to whether the drug or other substance should be controlled or removed from control. This request is sent to the Assistant Secretary of Health of HHS. HHS solicits information from the Commissioner of the Food and Drug Administration (FDA), evaluations and recommendations from the National Institute on Drug Abuse, and on occasion from the scientific and medical community at large. The Assistant Secretary, by authority of the Secretary, compiles the information and transmits back to the DEA a medical and scientific evaluation regarding the drug or other substance, a recommendation as to whether the drug should be controlled, and in what schedule it should be placed.

The medical and scientific evaluations are binding on the DEA with respect to scientific and medical matters and form a part of the

scheduling decision. The recommendation on the initial scheduling of a substance is binding only to the extent that if HHS recommends that the substance not be controlled, the DEA may not add it to the schedules.

Once the DEA has received the scientific and medical evaluation from HHS, the Administrator will evaluate all available data and make a final decision whether to propose that a drug or other substance should be removed or controlled and into which schedule it should be placed.

The threshold issue is whether the drug or other substance has potential for abuse. If a drug does not have a potential for abuse, it cannot be controlled. Although the term "potential for abuse" is not defined in the CSA, there is much discussion of the term in the legislative history of the Act. The following items are indicators that a drug or other substance has a potential for abuse:

1. There is evidence that individuals are taking the drug or other substance in amounts sufficient to create a hazard to their health or to the safety of other individuals or to the community; or
2. There is significant diversion of the drug or other substance from legitimate drug channels; or
3. Individuals are taking the drug or other substance on their own initiative rather than on the basis of medical advice from a practitioner licensed by law to administer such drugs; or
4. The drug is a new drug so related in its action to a drug or other substance already listed as having a potential for abuse to make it likely that the drug will have the same potential for abuse as such drugs, thus making it reasonable to assume that there may be significant diversions from legitimate channels, significant use contrary to or without medical advice, or that it has a substantial capability of creating hazards to the health of the user or to the safety of the community. Of course, evidence of actual abuse of a substance is indicative that a drug has a potential for abuse.

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In determining into which schedule a drug or other substance should be placed, or whether a substance should be decontrolled or rescheduled, certain factors are required to be considered. Specific findings are not required for each factor. These factors are listed in Section 201 (c), [21 U.S.C. 811 (c)] of the CSA as follows:

1. **The drug's actual or relative potential for abuse.**
2. **Scientific evidence of the drug's pharmacological effects.** The state of knowledge with respect to the effects of a specific drug is, of course, a major consideration. For example, it is vital to know whether or not a drug has a hallucinogenic effect if it is to be controlled due to that effect. The best available knowledge of the pharmacological properties of a drug should be considered.
3. **The state of current scientific knowledge regarding the substance.** Criteria (2) and (3) are closely related. However, (2) is primarily concerned with pharmacological effects and (3) deals with all scientific knowledge with respect to the substance.
4. **Its history and current pattern of abuse.** To determine whether or not a drug should be controlled, it is important to know the pattern of abuse of that substance, including the socio-economic characteristics of the segments of the population involved in such abuse.
5. **The scope, duration, and significance of abuse.** In evaluating existing abuse, the DEA Administrator must know not only the pattern of abuse, but whether the abuse is widespread. In reaching a decision, the Administrator should consider the economics of regulation and enforcement attendant to such a decision. In addition, the Administrator should be aware of the social significance and impact of such a decision upon those people, especially the young, that would be affected by it.
6. **What, if any, risk there is to the public health.** If a drug creates dangers to the public health, in addition to or because of its abuse potential, then these dangers must also be considered by the Administrator.
7. **The drug's psychic or physiological dependence liability.** There must be an assessment of the extent to which a drug is physically addictive or psychologically habit forming, if such information is known.
8. **Whether the substance is an immediate precursor of a substance already controlled.** The CSA allows inclusion of immediate precursors on this basis alone into the appropriate schedule and thus safeguards against possibilities of clandestine manufacture.

After considering the above listed factors, the Administrator must make specific findings concerning the drug or other substance. This will determine into which schedule the drug or other substance will be placed. These schedules are established by the CSA. They are as follows:

Schedule I

- The drug or other substance has a high potential for abuse.
- The drug or other substance has no currently accepted medical use in treatment in the United States.
- There is a lack of accepted safety for use of the drug or other substance under medical supervision.
- Examples of Schedule I substances include heroin, lysergic acid diethylamide (LSD), marijuana, and methaqualone.

Schedule II

- The drug or other substance has a high potential for abuse.
- The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
- Abuse of the drug or other substance may lead to severe psychological or physical dependence.
- Examples of Schedule II substances include morphine, phencyclidine (PCP), cocaine, methadone, and methamphetamine.

Schedule III

- The drug or other substance has less potential for abuse than the drugs or other substances in schedules I and II.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

- Anabolic steroids, codeine and hydrocodone with aspirin or Tylenol®, and some barbiturates are examples of Schedule III substances.

Schedule IV

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.
- Examples of drugs included in schedule IV are Darvon®, Talwin®, Equanil®, Valium®, and Xanax®.

Schedule V

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule IV.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substances may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.
- Cough medicines with codeine are examples of Schedule V drugs.

PROVIDED BY

Giving Hope Patient Care Collective

A nonprofit collective operated by patients for patients

In compliance with Health & Safety Code 11362.5 Prop 215 & Senate Bill 420

Frequently Asked Questions

Is medical cannabis legal?

Medical cannabis is legal under state and local law, but it is illegal under federal law. Voters in California legalized the use, cultivation, and possession of cannabis for those with a doctor's recommendation or approval when they adopted Proposition 215 in 1996. In 2003, the California State Assembly adopted Senate Bill 420 in order to implement and clarify Proposition 215 - effectively expanding its scope. Some of the content of that legislation and subsequent legal precedents inform the answers below. Unfortunately, medical cannabis remains illegal under federal law. We are working hard to resolve this conflict, but you should know that there can be serious legal consequences for breaking federal law.

Did the Supreme Court overturn California's law?

No. In 2005, The Supreme Court ruled that the federal government has jurisdiction to prosecute medical cannabis patients, cultivators, and providers despite the fact that their conduct is legal under state law. (Specifically, the *Gonzales v. Raich* case dealt with the jurisdiction of the federal government over local, non-commercial activity.) Visit <http://www.AmericansForSafeAccess.org/article.php?list=type&type=34> for more details about this case. *Absolutely nothing in the Court's decision preempted or overturned our state law.* Legal experts and the California Attorney General agree that our state law remains in force. Some people are under the mistaken impression that federal law trumps state law in any case. This is false. The interaction of state and federal law under our federalist system of government is complex and controversial. Conflicts are not unheard of, and state law can stand in opposition to federal law in cases like this.

What is a medical cannabis dispensing collective?

A medical cannabis dispensing collective is an organization operating in compliance with state law and comprised entirely of legally-qualified patients and their primary caregivers that receives medicine exclusively from its members and provides it exclusively to its members. Collectives are sometimes called dispensaries, compassion clubs, or cannabis centers. The exact terminology varies, and terms are sometimes used inter-changeably. I prefer the term *dispensing collective* to clearly associate these organizations with California law as discussed below.

Are collectives legal under state law?

Yes. California Health and Safety Code §11362.775 authorizes patients and caregivers to "associate within the State of California in order *collectively or cooperatively* to cultivate marijuana for medical purposes" [italics added]. Unfortunately, the law gives no further clarification as to what constitutes a collective or cooperative association. The nature of these associations is evolving in step with California law and legal precedents.

In August 2008, the California Attorney General (AG) published guidelines for medical cannabis that state that "a properly organized and operated collective of cooperative that

dispenses medical marijuana through a storefront may be lawful under California law," provided the facility substantially complies with the AG's guidelines. You should read "What the Attorney General's Guidelines Mean for Medical Cannabis Dispensing Collectives in California" at <http://www.AmericansForSafeAccess.org/AGGuidelines> for a detailed discussion of collectives and cooperatives under California law.

Does a collective have to be a nonprofit organization?

California Health and Safety Code Section 11362.765(a) says that nothing in the law authorizes the cultivation of medical cannabis for profit. This statute does not mandate the establishment of a statutory nonprofit corporation as described in California Corporations Code Section 5000, *et seq.* However, operators may *choose* to organize a medical cannabis collective as a California nonprofit corporation, as discussed in greater detail below.

Regardless of the organizational structure, a medical cannabis collective should operate in a "not-for-profit" manner. **Not-for-profit** operation describes the behavior of a business or association that is not operated for a commercial purpose, or to generate profits for its owners. Any business, regardless of its formal structure, can operate in a not-for-profit fashion by reinvesting excess revenue (after salaries and other overhead) in services for members, advocacy for patients' rights, or other noncommercial activity.

The term not-for-profit is sometimes confused with the term nonprofit. A **nonprofit corporation** is a specific statutory entity organized under California Corporation Code Section 5000, *et seq.*, to carry on a non-commercial activity. Nonprofit corporations include churches, schools, some hospitals, social clubs, and service organizations. Some nonprofits are exempt from federal and state taxes because they do educational, religious, or charitable work. The Internal Revenue Service will not recognize providing medical cannabis as a tax-exempt activity, and state tax-exemption is contingent on federal approval. Therefore, a medical cannabis collective organized as a nonprofit corporation will report and pay tax like a traditional C-Corporation. It is important to remember, however, that a corporation is still a legitimate nonprofit organization under California law, even without tax-exempt status.

Many collective operators choose to incorporate their collectives as **California Nonprofit Mutual Benefit Corporations**, as described under California Corporations Code 7110, *et seq.* Doing so gives the collective a bona fide nonprofit identity, something that resonates with elected officials, law enforcement, media, and neighbors. This is a sensible choice for most operators, and increasingly the norm for new facilities.

Do I need permission from the Police Department?

Unless your city or county requires it, you do not need approval from law enforcement. The Police Department is likely to oppose a new collective. In fact, law enforcement has always been the leading opponent of medical cannabis. Do not expect a lot of support from your local police department. However, you do need to talk to them just before or shortly after you open your doors. You do not want your first interaction with

the Police Department to be by surprise. Do not ask for permission - simply inform and include.

Where do you get your medicine?

A dispensing collective must obtain its medication from its registered members. This is a significant challenge for new dispensing collectives. You have to build your membership base before you have enough members to provide excess medication to supply the others. This may be very frustrating for new operators, but is an important phase to get through. Your members will understand if you do not have a wide selection when you first open. Encourage those members who do grow cannabis to bring their excess medication back to the collective to help the other members. Some legally qualified medical cannabis patients are very good at growing medicine. In fact, some have relatively large stores of excess medication. These fortunate patients will often be looking for a dispensing collective or cooperative to join. Some people refer to these patients as "vendors." A better term is *patient-cultivator*. It has been my experience that these patient-cultivators will find you when you open your collective. I am sorry to say that I cannot help you locate medication for your new dispensing collective.

Do I have to pay sales tax?

Yes. The California BOE has decided that all collectives must obtain a seller's permit and pay sales tax. I believe this is an unfortunate decision that places an undue burden on patients while ignoring the intent of voters and the State Assembly. Nevertheless, you should collect and pay sales tax on every transaction. You may face serious financial and legal consequences if you do not.

California Medical Cannabis Collectives

COMPLETE LIST FOUND AT www.canorml.org

North Coast

- Humboldt Patient Resource Center, 980 6th St. **Arcata** 707-826-7988 Open 10-5 M-Th, 10-5:30 F.
- Arcata iCenter, 1085 K St. **Arcata** (707) 496-9769 Open Mon-Fri 10-7, Sat 11-7, Sun 12-5.
- Herban Legend, 17851 N. Hwy 1, **Fort Bragg** (707) 961-0113; M-Sa 11am-6pm.
- Sonoma Patient Group, 2425 Cleveland Ave #175 **Santa Rosa** (707) 526-2800.
- [Organic Cannabis Foundation](#) - 301 E. Todd Rd, **Santa Rosa** (707) 588-881 Open 10-6:45 M-F; 10-4:45 Sa.
- [Peace in Medicine](#), 6771 Sebastopol Ave (Hwy. 12), **Sebastopol** (707) 823-4206 Open Tu-Sa 10:30-7; Su-M 10:30- 5.
- Sonoma Alliance for Med MJ (707) 522-0292 - Advocacy & education (Does not distribute).
- Sonoma (**Guerneville**): Marvin's Gardens 707-869-1291
- Lake Co D & M Compassion Center, 15196 Lakeshore Blvd, **Clearlake** (707) 994-1320
- The Patient's Choice, 9440 Main St., **Upper Lake** (707) 275-9564 Open M-Sa 10-6.
- [Patients Resource Compassionate Care Coalition](#), 9781 Point Lakeview Rd #2, **Kelseyville** (707) 277-8300. Open Su-Th 11-7, F-Sa Noon-8.
- [Good Karma Growers Collective](#), 6045 Second Ave. **Lucerne** (707) 274-2144
- The Humboldt Cooperative 601 I St., Suite 2 **Arcata** (707) 822-9330. Open Mon-Thu 10-5:30; Fri 10-6, Sat 10-5:30.
- Caregiver Compassion Group, 2425 Cleveland Ave #140, **Santa Rosa** (707) 542-7303.
- Northern California Collective & Vapor Lounge 8050 Lake St. **Lower Lake** (707) 998-5248
- Compassionate Heart 2020 Industry Rd. **Ukiah** (707) 462-5100 Open Tue, Wed, Fri, Sat 11-7; Thurs 1-7. micromike420@att.net
- [Going Green](#) 611 Soscol, Unit 102 **Napa** (707) 253-2646 Open daily 11-8

Central Valley & Foothills to Redding

- [MMCA](#), Cameron Park (**El Dorado Co.**) (530) 677-5362
- Golden State Patient Care Collective, 233 Hwy 174, **Colfax** (530) -346-2514. M, Tu, W, Sat 10 - 5; Th-Fr 10-6.
- Trusted Friends Inc. 2030 California St. **Redding** (530) 229-1920. Open Mon. - Sat. 11:00 - 7:00
trustedfriends420@yahoo.com
- **Yuba County** Cannabis Buyers' Collective (530) 749-7497
- **Stanislaus**/Central Valley Co-op: Primary Caregivers & Consultants (209) 818-2932 CACaregivers@aol.com
- MEDMAR Clinic Dispensing Collective 210 East Olive **Fresno** (559) 442-8420 Open Mon-Sat 12-6
medmarclinic@att.net
- Cal Patient Collectives 2728 Churn Creek Rd. **Redding** (530) 221-3790 Open 8-8.
- WDH Precious Safe House 2849 Bechellie Rd. **Redding** (530) 221-3723 Open 8-8.
- Nature's 420, 1133 Hilltop (In Town & Country Center) **Redding** (530) 605-0545. Open Mon-Sat 11-7.
- [Sierra Natural Healing Collective](#) 5030 West Shaw Ave. **Fresno** Open Tue-Sun 12-7.
- The Green Heart Collective 3056 West Center St. **Anderson** (530) 365-8500 Mon-Sat 10-8, Sun 10-6.
- Trinity Gardens Inc. 2160 Railroad Ave. **Redding** (530) 510-4462 Open Mon-Sat 10-8; Sun 12-5.

Sacramento

- Canna Care, 320 Harris Ave #G **Sacramento** (916) 925-1199 Daily 10-8.
- Marconi Medical Center, 2105 Marconi Ave, **Sacramento** (916) 565-1943. Open M-Sa 10-7, Su 10-5.
- Doctor's Orders, 1704 Main Ave, **Sacramento** (916) 564-2112 Open M-Sa 10-6, Su 10-3.
- Nor Cal Alternative Healing, 515 Broadway, **Sacramento** (916) 448-3590. Open M-Sa 10-7.

- Sacramento Healing Center, 2014 10th St, **Sacramento** (916) 930-0939. Open 10am-10pm M-Sa, 12-5pm Sun.
- Hugs Alternative Care, 2035 Stockton Blvd, **Sacramento** (916) 452-3699. Open 10-8.
- Mendomeds, 277 Arden Way, **Sacramento** organic (916) 349-8873 or (916) 349-8263. Open M-Sa 10-8, Su 10-5. mendomeds@hotmail.com
- 12 Hour Care Collective, 6666-C Fruitridge Blvd. **Sacramento** (916) 386-9727. Open daily noon-8pm.
- El Camino Wellness Center Collective, 2511 Connie Dr, Ste. 200 **Sacramento** (916)473-2427. Open 10:30-7 M-Sa, 1-6 Su. elcaminowellnesscenter@gmail.com
- Horizon Non-Profit Collective, 3600 Power Inn Road 1A, **Sacramento** (916) 455-1931.
- Unity Non Profit Collective, 1832 Tribute Rd. Suite E **Sacramento** (916) 564-1824 Open M-Sat 10-7, Sun 12-5.
- Green Solutions, 3318 Broadway, **Sacramento** (916) 706-3568. Open daily 10-7.
- P Street Health Care Cooperative, 2012 P. Street **Sacramento** (916) 930-1920 Open M-F 10-6, Sat/Sun 11-6.
- Fruitridge Health and Wellness Center (FHWC) 2831 Fruitridge Rd Suite E **Sacramento** 916-706-3806 Open daily 11-6
- Capitol Wellness Collective, 2100 29th St. **Sacramento** (916) 739-1471 Open 10 a.m. to 7 p.m.
- A Therapeutic Alternative 3015 H. Street **Sacramento** (916) 400-3095 Open M-F 10-7, Sat 10-6. atherapeuticalternative@yahoo.com
- SacsterDam U, **Sacramento** (916) 222-9030 Hourly Appointments 12p-10p. sacsterdamu@gmail.com
- Americann Collectives Dispensary 1855 Diesel Drive Suite #1 **Sacramento** (916) 927-0237 Open Sun-Thurs. 8:30-8:30; Fri-Sat.8:30-10
- South Sacramento Care Center 114A Otto Circle **Sacramento** (916) 393-1820 Open daily 9-7.

- EBHS Collective of Sacramento 2201 Northgate Blvd. Suite H **Sacramento** (916) 564-6625 Open Mon-Sat 10-6
- Valley Health Options 1421 Auburn Blvd. **Sacramento** (916) 779-0715 Open Tues-Sat 10-6.
- Best Cannabis Care 9261 Folsom Blvd. Suite 703 **Sacramento** (916) 635-7916 Open Mon-Sat 11-7.
bc_care@yahoo.com

EXAMPLES INTERIOR MEDICAL MARIJUANA DISPENSARY





**GUIDELINES FOR THE SECURITY AND NON-DIVERSION
OF MARIJUANA GROWN FOR MEDICAL USE**

August 2008

In 1996, California voters approved an initiative that exempted certain patients and their primary caregivers from criminal liability under state law for the possession and cultivation of marijuana. In 2003, the Legislature enacted additional legislation relating to medical marijuana. One of those statutes requires the Attorney General to adopt “guidelines to ensure the security and nondiversion of marijuana grown for medical use.” (Health & Saf. Code, § 11362.81(d).¹) To fulfill this mandate, this Office is issuing the following guidelines to (1) ensure that marijuana grown for medical purposes remains secure and does not find its way to non-patients or illicit markets, (2) help law enforcement agencies perform their duties effectively and in accordance with California law, and (3) help patients and primary caregivers understand how they may cultivate, transport, possess, and use medical marijuana under California law.

I. SUMMARY OF APPLICABLE LAW

A. California Penal Provisions Relating to Marijuana.

The possession, sale, cultivation, or transportation of marijuana is ordinarily a crime under California law. (See, e.g., § 11357 [possession of marijuana is a misdemeanor]; § 11358 [cultivation of marijuana is a felony]; Veh. Code, § 23222 [possession of less than 1 oz. of marijuana while driving is a misdemeanor]; § 11359 [possession with intent to sell any amount of marijuana is a felony]; § 11360 [transporting, selling, or giving away marijuana in California is a felony; under 28.5 grams is a misdemeanor]; § 11361 [selling or distributing marijuana to minors, or using a minor to transport, sell, or give away marijuana, is a felony].)

B. Proposition 215 - The Compassionate Use Act of 1996.

On November 5, 1996, California voters passed Proposition 215, which decriminalized the cultivation and use of marijuana by seriously ill individuals upon a physician’s recommendation. (§ 11362.5.) Proposition 215 was enacted 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,” and to “ensure that patients and their primary caregivers who obtain and use marijuana for

¹ Unless otherwise noted, all statutory references are to the Health & Safety Code.

medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.” (§ 11362.5(b)(1)(A)-(B).)

The Act further states that “Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient’s primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or verbal recommendation or approval of a physician.” (§ 11362.5(d).) Courts have found an implied defense to the transportation of medical marijuana when the “quantity transported and the method, timing and distance of the transportation are reasonably related to the patient’s current medical needs.” (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1551.)

C. Senate Bill 420 - The Medical Marijuana Program Act.

On January 1, 2004, Senate Bill 420, the Medical Marijuana Program Act (MMP), became law. (§§ 11362.7-11362.83.) The MMP, among other things, requires the California Department of Public Health (DPH) to establish and maintain a program for the voluntary registration of qualified medical marijuana patients and their primary caregivers through a statewide identification card system. Medical marijuana identification cards are intended to help law enforcement officers identify and verify that cardholders are able to cultivate, possess, and transport certain amounts of marijuana without being subject to arrest under specific conditions. (§§ 11362.71(e), 11362.78.)

It is mandatory that all counties participate in the identification card program by (a) providing applications upon request to individuals seeking to join the identification card program; (b) processing completed applications; (c) maintaining certain records; (d) following state implementation protocols; and (e) issuing DPH identification cards to approved applicants and designated primary caregivers. (§ 11362.71(b).)

Participation by patients and primary caregivers in the identification card program is voluntary. However, because identification cards offer the holder protection from arrest, are issued only after verification of the cardholder’s status as a qualified patient or primary caregiver, and are immediately verifiable online or via telephone, they represent one of the best ways to ensure the security and non-diversion of marijuana grown for medical use.

In addition to establishing the identification card program, the MMP also defines certain terms, sets possession guidelines for cardholders, and recognizes a qualified right to collective and cooperative cultivation of medical marijuana. (§§ 11362.7, 11362.77, 11362.775.)

D. Taxability of Medical Marijuana Transactions.

In February 2007, the California State Board of Equalization (BOE) issued a Special Notice confirming its policy of taxing medical marijuana transactions, as well as its requirement that businesses engaging in such transactions hold a Seller’s Permit. (<http://www.boe.ca.gov/news/pdf/medseller2007.pdf>.) According to the Notice, having a Seller’s Permit does not allow individuals to make unlawful sales, but instead merely provides a way to remit any sales and use taxes due. BOE further clarified its policy in a

June 2007 Special Notice that addressed several frequently asked questions concerning taxation of medical marijuana transactions. (<http://www.boe.ca.gov/news/pdf/173.pdf>.)

E. Medical Board of California.

The Medical Board of California licenses, investigates, and disciplines California physicians. (Bus. & Prof. Code, § 2000, et seq.) Although state law prohibits punishing a physician simply for recommending marijuana for treatment of a serious medical condition (§ 11362.5(c)), the Medical Board can and does take disciplinary action against physicians who fail to comply with accepted medical standards when recommending marijuana. In a May 13, 2004 press release, the Medical Board clarified that these accepted standards are the same ones that a reasonable and prudent physician would follow when recommending or approving any medication. They include the following:

1. Taking a history and conducting a good faith examination of the patient;
2. Developing a treatment plan with objectives;
3. Providing informed consent, including discussion of side effects;
4. Periodically reviewing the treatment's efficacy;
5. Consultations, as necessary; and
6. Keeping proper records supporting the decision to recommend the use of medical marijuana.

(http://www.mbc.ca.gov/board/media/releases_2004_05-13_marijuana.html.)

Complaints about physicians should be addressed to the Medical Board (1-800-633-2322 or www.mbc.ca.gov), which investigates and prosecutes alleged licensing violations in conjunction with the Attorney General's Office.

F. The Federal Controlled Substances Act.

Adopted in 1970, the Controlled Substances Act (CSA) established a federal regulatory system designed to combat recreational drug abuse by making it unlawful to manufacture, distribute, dispense, or possess any controlled substance. (21 U.S.C. § 801, et seq.; *Gonzales v. Oregon* (2006) 546 U.S. 243, 271-273.) The CSA reflects the federal government's view that marijuana is a drug with "no currently accepted medical use." (21 U.S.C. § 812(b)(1).) Accordingly, the manufacture, distribution, or possession of marijuana is a federal criminal offense. (*Id.* at §§ 841(a)(1), 844(a).)

The incongruity between federal and state law has given rise to understandable confusion, but no legal conflict exists merely because state law and federal law treat marijuana differently. Indeed, California's medical marijuana laws have been challenged unsuccessfully in court on the ground that they are preempted by the CSA. (*County of San Diego v. San Diego NORML* (July 31, 2008) --- Cal.Rptr.3d ----, 2008 WL 2930117.) Congress has provided that states are free to regulate in the area of controlled substances, including marijuana, provided that state law does not positively conflict with the CSA. (21 U.S.C. § 903.) Neither Proposition 215, nor the MMP, conflict with the CSA because, in adopting these laws, California did not "legalize" medical marijuana, but instead exercised the state's reserved powers to not punish certain marijuana offenses under state law when a

physician has recommended its use to treat a serious medical condition. (See *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355, 371-373, 381-382.)

In light of California's decision to remove the use and cultivation of physician-recommended marijuana from the scope of the state's drug laws, this Office recommends that state and local law enforcement officers not arrest individuals or seize marijuana under federal law when the officer determines from the facts available that the cultivation, possession, or transportation is permitted under California's medical marijuana laws.

II. DEFINITIONS

A. **Physician's Recommendation:** Physicians may not prescribe marijuana because the federal Food and Drug Administration regulates prescription drugs and, under the CSA, marijuana is a Schedule I drug, meaning that it has no recognized medical use. Physicians may, however, lawfully issue a verbal or written recommendation under California law indicating that marijuana would be a beneficial treatment for a serious medical condition. (§ 11362.5(d); *Conant v. Walters* (9th Cir. 2002) 309 F.3d 629, 632.)

B. **Primary Caregiver:** A primary caregiver is a person who is designated by a qualified patient and "has consistently assumed responsibility for the housing, health, or safety" of the patient. (§ 11362.5(e).) California courts have emphasized the consistency element of the patient-caregiver relationship. Although a "primary caregiver who consistently grows and supplies . . . medicinal marijuana for a section 11362.5 patient is serving a health need of the patient," someone who merely maintains a source of marijuana does not automatically become the party "who has consistently assumed responsibility for the housing, health, or safety" of that purchaser. (*People ex rel. Lungren v. Peron* (1997) 59 Cal.App.4th 1383, 1390, 1400.) A person may serve as primary caregiver to "more than one" patient, provided that the patients and caregiver all reside in the same city or county. (§ 11362.7(d)(2).) Primary caregivers also may receive certain compensation for their services. (§ 11362.765(c) ["A primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided . . . to enable [a patient] to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services, or both, . . . shall not, on the sole basis of that fact, be subject to prosecution" for possessing or transporting marijuana].)

C. **Qualified Patient:** A qualified patient is a person whose physician has recommended the use of marijuana to treat a serious illness, including cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief. (§ 11362.5(b)(1)(A).)

D. **Recommending Physician:** A recommending physician is a person who (1) possesses a license in good standing to practice medicine in California; (2) has taken responsibility for some aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient; and (3) has complied with accepted medical standards (as described by the Medical Board of California in its May 13, 2004 press release) that a reasonable and prudent physician would follow when recommending or approving medical marijuana for the treatment of his or her patient.

III. GUIDELINES REGARDING INDIVIDUAL QUALIFIED PATIENTS AND PRIMARY CAREGIVERS

A. State Law Compliance Guidelines.

1. **Physician Recommendation:** Patients must have a written or verbal recommendation for medical marijuana from a licensed physician. (§ 11362.5(d).)

2. **State of California Medical Marijuana Identification Card:** Under the MMP, qualified patients and their primary caregivers may voluntarily apply for a card issued by DPH identifying them as a person who is authorized to use, possess, or transport marijuana grown for medical purposes. To help law enforcement officers verify the cardholder's identity, each card bears a unique identification number, and a verification database is available online (www.calmmp.ca.gov). In addition, the cards contain the name of the county health department that approved the application, a 24-hour verification telephone number, and an expiration date. (§§ 11362.71(a); 11362.735(a)(3)-(4); 11362.745.)

3. **Proof of Qualified Patient Status:** Although verbal recommendations are technically permitted under Proposition 215, patients should obtain and carry written proof of their physician recommendations to help them avoid arrest. A state identification card is the best form of proof, because it is easily verifiable and provides immunity from arrest if certain conditions are met (see section III.B.4, below). The next best forms of proof are a city- or county-issued patient identification card, or a written recommendation from a physician.

4. Possession Guidelines:

a) **MMP:**² Qualified patients and primary caregivers who possess a state-issued identification card may possess 8 oz. of dried marijuana, and may maintain no more than 6 mature or 12 immature plants per qualified patient. (§ 11362.77(a).) But, if "a qualified patient or primary caregiver has a doctor's recommendation that this quantity does not meet the qualified patient's medical needs, the qualified patient or primary caregiver may possess an amount of marijuana consistent with the patient's needs." (§ 11362.77(b).) Only the dried mature processed flowers or buds of the female cannabis plant should be considered when determining allowable quantities of medical marijuana for purposes of the MMP. (§ 11362.77(d).)

b) **Local Possession Guidelines:** Counties and cities may adopt regulations that allow qualified patients or primary caregivers to possess

² On May 22, 2008, California's Second District Court of Appeal severed Health & Safety Code § 11362.77 from the MMP on the ground that the statute's possession guidelines were an unconstitutional amendment of Proposition 215, which does not quantify the marijuana a patient may possess. (See *People v. Kelly* (2008) 163 Cal.App.4th 124, 77 Cal.Rptr.3d 390.) The Third District Court of Appeal recently reached a similar conclusion in *People v. Phomphakdy* (July 31, 2008) --- Cal.Rptr.3d ---, 2008 WL 2931369. The California Supreme Court has granted review in *Kelly* and the Attorney General intends to seek review in *Phomphakdy*.

medical marijuana in amounts that exceed the MMP's possession guidelines. (§ 11362.77(c).)

c) **Proposition 215:** Qualified patients claiming protection under Proposition 215 may possess an amount of marijuana that is “reasonably related to [their] current medical needs.” (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1549.)

B. Enforcement Guidelines.

1. **Location of Use:** Medical marijuana may not be smoked (a) where smoking is prohibited by law, (b) at or within 1000 feet of a school, recreation center, or youth center (unless the medical use occurs within a residence), (c) on a school bus, or (d) in a moving motor vehicle or boat. (§ 11362.79.)

2. **Use of Medical Marijuana in the Workplace or at Correctional Facilities:** The medical use of marijuana need not be accommodated in the workplace, during work hours, or at any jail, correctional facility, or other penal institution. (§ 11362.785(a); *Ross v. RagingWire Telecomms., Inc.* (2008) 42 Cal.4th 920, 933 [under the Fair Employment and Housing Act, an employer may terminate an employee who tests positive for marijuana use].)

3. **Criminal Defendants, Probationers, and Parolees:** Criminal defendants and probationers may request court approval to use medical marijuana while they are released on bail or probation. The court's decision and reasoning must be stated on the record and in the minutes of the court. Likewise, parolees who are eligible to use medical marijuana may request that they be allowed to continue such use during the period of parole. The written conditions of parole must reflect whether the request was granted or denied. (§ 11362.795.)

4. **State of California Medical Marijuana Identification Cardholders:** When a person invokes the protections of Proposition 215 or the MMP and he or she possesses a state medical marijuana identification card, officers should:

a) Review the identification card and verify its validity either by calling the telephone number printed on the card, or by accessing DPH's card verification website (<http://www.calmmp.ca.gov>); and

b) If the card is valid and not being used fraudulently, there are no other indicia of illegal activity (weapons, illicit drugs, or excessive amounts of cash), and the person is within the state or local possession guidelines, the individual should be released and the marijuana should not be seized. Under the MMP, “no person or designated primary caregiver in possession of a valid state medical marijuana identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana.” (§ 11362.71(e).) Further, a “state or local law enforcement agency or officer shall not refuse to accept an identification card issued by the department unless the state or local law enforcement agency or officer

has reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently.” (§ 11362.78.)

5. **Non-Cardholders:** When a person claims protection under Proposition 215 or the MMP and only has a locally-issued (i.e., non-state) patient identification card, or a written (or verbal) recommendation from a licensed physician, officers should use their sound professional judgment to assess the validity of the person’s medical-use claim:

a) Officers need not abandon their search or investigation. The standard search and seizure rules apply to the enforcement of marijuana-related violations. Reasonable suspicion is required for detention, while probable cause is required for search, seizure, and arrest.

b) Officers should review any written documentation for validity. It may contain the physician’s name, telephone number, address, and license number.

c) If the officer reasonably believes that the medical-use claim is valid based upon the totality of the circumstances (including the quantity of marijuana, packaging for sale, the presence of weapons, illicit drugs, or large amounts of cash), and the person is within the state or local possession guidelines or has an amount consistent with their current medical needs, the person should be released and the marijuana should not be seized.

d) Alternatively, if the officer has probable cause to doubt the validity of a person’s medical marijuana claim based upon the facts and circumstances, the person may be arrested and the marijuana may be seized. It will then be up to the person to establish his or her medical marijuana defense in court.

e) Officers are not obligated to accept a person’s claim of having a verbal physician’s recommendation that cannot be readily verified with the physician at the time of detention.

6. **Exceeding Possession Guidelines:** If a person has what appears to be valid medical marijuana documentation, but exceeds the applicable possession guidelines identified above, all marijuana may be seized.

7. **Return of Seized Medical Marijuana:** If a person whose marijuana is seized by law enforcement successfully establishes a medical marijuana defense in court, or the case is not prosecuted, he or she may file a motion for return of the marijuana. If a court grants the motion and orders the return of marijuana seized incident to an arrest, the individual or entity subject to the order must return the property. State law enforcement officers who handle controlled substances in the course of their official duties are immune from liability under the CSA. (21 U.S.C. § 885(d).) Once the marijuana is returned, federal authorities are free to exercise jurisdiction over it. (21 U.S.C. §§ 812(c)(10), 844(a); *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355, 369, 386, 391.)

IV. GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

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

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

1. **Statutory Cooperatives:** A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. (Corp. Code, § 12201, 12300.) No business may call itself a “cooperative” (or “co-op”) unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code. (*Id.* at § 12311(b).) Cooperative corporations are “democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons.” (*Id.* at § 12201.) The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (*Ibid.*) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. (See *id.* at § 12200, et seq.) Agricultural cooperatives are likewise nonprofit corporate entities “since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers.” (Food & Agric. Code, § 54033.) Agricultural cooperatives share many characteristics with consumer cooperatives. (See, e.g., *id.* at § 54002, et seq.) 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.” (*Random House Unabridged Dictionary*; Random House, Inc. © 2006.) 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.

B. Guidelines for the Lawful Operation of a Cooperative or Collective:

Collectives and cooperatives should be organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws. The following are some suggested guidelines and practices for operating collective growing operations to help ensure lawful operation.

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

2. **Business Licenses, Sales Tax, and 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:

a) Verify the individual’s status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician’s identity, as well as his or her state licensing status. Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient’s recommendation. Copies should be made of the physician’s recommendation or identification card, if any;

b) Have the individual agree not to distribute marijuana to non-members;

c) Have the individual agree not to use the marijuana for other than medical purposes;

d) Maintain membership records on-site or have them reasonably available;

e) Track when members’ medical marijuana recommendation and/or identification cards expire; and

f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are invalid or have expired, or who are caught diverting marijuana for non-medical use.

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

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

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

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

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

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

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

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

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

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