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DEC 19 2014

WILLIAM F. PENTNEY
Solicitor for
A.G.C.

BETWEEN:

NEIL ALLARD
TANYA BEEMISH
DAVID HEBERT
SHAWN DAVEY

PLAINTIFFS

AND:

HER MAJESTY THE QUEEN IN RIGHT OF CANADA

DEFENDANTS

AFFIDAVIT OF PAUL ARMENTANO

I, PAUL ARMENTANO, NORML, 1100 H Street, NW, Suite 830, Washington, DC, MAKE OATH AND SAY AS FOLLOWS, THAT:

1. My name is Paul Armentano, and I am the Deputy Director for the National Organization for the Reform of Marijuana Laws, and I make this affidavit of my own personal knowledge, information and belief. Where matters are stated to be on information and belief I so indicate and believe them to be true.

2. Now produced and marked as Exhibit "A" to this my Affidavit is my Rebuttal Expert Report.

3. Now produced and marked as Exhibit "B" to this my Affidavit is my Certificate Concerning Code of Conduct for Expert Witnesses.

4. I swear this Affidavit as an expert rebuttal witness on behalf of the Plaintiffs in this action.

SWORN BEFORE ME this 16 day of December, 2014

PAUL ARMENTANO

State of California
County of Solano

Subscribed and sworn to (or affirmed) before me on this 16 day of Dec, 2014 by Paul Armentano, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature (Notary seal)

GRACIELA CURIEL
Commission # 2030231
Notary Public - California
Solano County
My Comm. Expires Jun 22, 2017

State of California
County of Solano
Subscribed and sworn to (or affirmed) before me on this 16 day of Dec, 2014 by Paul Armentano, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.
Signature (Notary seal)

This is Exhibit "A" referred to in the affidavit of Paul Armentano 12/16/14

GRACIELA CURIEL
Commission # 2030231
Notary Public - California
Solano County
My Comm. Expires Jun 22, 2017

EXPERT REPORT
PAUL ARMENTANO

(*a*) a statement of the issues addressed in the report;

This report addresses and responds to the issues raised in the affidavit and expert report of Lynn Whipkey Mehler, lawyer, of October 20th 2014, and Robert Mikos, Professor of Law, of October 14th, 2014 with respect to the implementation of state-specific medical cannabis laws in the United States of America.

(*b*) a description of the qualifications of the expert on the issues addressed in the report;

I am the Deputy Director of the National Organization for the Reform of Marijuana Laws (NORML), a Washington, DC-based nonprofit advocacy organization that lobbies for changes in state and federal laws in order to minimize or eliminate criminal and/or civil penalties specific to the responsible consumption of cannabis by adults. I have served as an employee of NORML in various capacities for a total of 17 years. During my tenure at NORML I have authored various papers, reports, and commentaries specific to the subject of cannabis and public policy, many of which have included analyses in regard to plant's evolving legal status under state and federal law. I have assisted directly with both legislative and voter-initiative led campaigns to successfully amend the legal status of cannabis at the state level. I have provided oral and/or written testimony regarding the topic of cannabis' legal status before various state legislatures and also before federal agencies. On many occasions, my testimony advocated specifically for changes in state laws specific to the use and distribution of cannabis for therapeutic purposes. I have closely reviewed the statutory language specific to all state medical cannabis laws and I am frequently requested by members of the national media and lawmakers to provide my opinions in regard to these measures as well as to the status of their implementation. I am also the primary content provider for the NORML.org website, which summarizes the status of US state medical cannabis laws and periodically reports on any significant legislative changes to these measures.

(c) the expert's current *curriculum vitae* attached to the report as a schedule;

My CV is attached as Schedule "A"

(*d*) the facts and assumptions on which the opinions in the report are based; in that regard, a letter of instructions, if any, may be attached to the report as a schedule;

I was inquired by Counsel to review the affidavit and expert reports of Ms. Mehler and Mr. Mikos and to advise Counsel of any issues or facts requiring any rebuttal to ensure the court has a complete and accurate picture in regard

the legal status of medical cannabis in the United States as well as the ongoing implementation of state-specific laws permitting the plant's (or its constituents') consumption, production, and/or distribution.

(*e*) a summary of the opinions expressed;

While it is apparent that several US states have adopted some form of legislation intending to facilitate state-sponsored production and distribution of medical cannabis and/or specific cannabinoid preparations, in practice, qualified patients in many of these jurisdictions, to date, lack adequate and/or safe access to said products because these proposed programs are either non-operational and/or fail to provide a feasible mechanism to allow for the state-licensed manufacture and dispensing of either cannabis or cannabis-derived products. Because of this reality, it is arguable whether, from a patients' perspective, state laws mandating commercial medical cannabis cultivation and distribution only are preferable to those permitting patients the legal option to engage in limited home cultivation.

(*f*) in the case of a report that is provided in response to another expert's report, an indication of the points of agreement and of disagreement with the other expert's opinions;

With respect to the expert report of Lynn Mehler's, it is my opinion that the statement, "[C]urrently 35 jurisdictions in the United States ... permit the medical use of marijuana outside of a federal government sanctioned clinical trial" is not entirely accurate. In fact, several jurisdictions included in Ms. Mehler's tally explicitly fail to permit qualified patients access to cannabis in its whole-plant form.

For example, statutes enacted in 2014 in Minnesota and in New York seek only to permit qualified patients legal access to non-smoked cannabinoid preparations (in the form of oils or pills). These statutes explicitly forbid qualified patients from possessing or obtaining the cannabis plant or its flowers (where the highest percentage of the plant's cannabinoids are concentrated). Under these laws, only those entities licensed by the state to produce cannabis for the purpose of cannabinoid extraction are permitted.

Moreover, 11 additional states – Alabama, Florida, Iowa, Kentucky, Mississippi, Missouri, North Carolina, South Carolina, Tennessee, Utah, and Wisconsin – enacted statutes in 2014 that limit qualified patients to the possession of oil extracts predominant in a specific plant cannabinoid known as cannabidiol (CBD). These statutes do not permit qualified patients to possess the actual cannabis plant or its flowers and, in fact, only two of these states – Florida and Missouri – possess existing statutory language permitting the state to license private cultivators to grow, in state, the source material (cannabis plant strains possessing elevated CBD content) necessary for the manufacturing of these high CBD extracts. (In November, Florida's regulations for licensing cultivators

were rejected by an administrative law judge.) Laws in the states of Alabama and Kentucky only permit patients' access to cannabidiol if they are participants in a state-sponsored university trial – in which case the US federal government, not any state-specific agency, would arguably be the sole legal provider of the compound. Laws in the other seven CBD-specific states, at present, do not provide a clear mechanism in regard to how qualified patients would actually obtain high CBD products and/or how state officials would produce, distribute, or regulate said products.

By contrast, the other 22 jurisdictions cited by Ms. Mehler: Alaska, Arizona, California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington do permit (or seek to permit) either state-qualified patients and/or state-licensed providers to produce cannabis for therapeutic purposes. However, to date, most state programs mandating state-licensed providers as the sole legal cultivators and distributors of medical cannabis to qualified patients (and, therefore, prohibit patients from growing their own supply) are not yet fully – or even partially – operational.

At the present time, such programs are only partially implemented or have yet to be implemented in the following states: Connecticut (partially implemented), Delaware (not yet implemented), Illinois (not yet implemented), Maryland (not yet implemented), New Hampshire (not yet implemented), and New Jersey (partially implemented). This means that in practice, in these states, patients are still entirely without (or, in the instances of patients in Connecticut or New Jersey, largely without) any legal supply of medical cannabis and, in most cases, continue to face legal sanctions if they elect to either cultivate their own personal supply of cannabis or attempt to obtain it from the underground market.

In several of these states, such as Connecticut, Delaware, and New Jersey, several years have elapsed since the passage of the state's medical cannabis law and the partial or full establishment of state-licensed providers. (Specifically, despite Delaware lawmakers enacting medical cannabis production and distribution legislation in 2011, no such state-sponsored activities have yet to occur. In Connecticut and New Jersey, fewer than the total number of licensed facilities allowed by law are presently operational.) Similarly, Massachusetts voters enacted initiative legislation in 2012 to provide for the state-licensed production and distribution of medical cannabis to qualified patients, but to date, no such production or distribution facilities are operational. (Although the legislation does allow for patients to possess the limited capacity to cultivate their own cannabis if they can demonstrate special circumstances, such as a verified financial or physical hardship, I am unaware at this time of any data estimating what percentage of state-qualified patients are engaging in this limited option.) Lawmakers in Illinois and New Hampshire enacted their

respective state laws in the spring of 2013. At present, no state-sponsored production or distribution of medical cannabis has yet to occur.

This reality would appear to contradict presumptions declared in the affidavit of Mr. Mikos. Specifically, his proposed timeline of "one year or more" (in regard to the estimated period of time that would typically elapse between the time a state initially begins to promulgates regulations and actually begins the process of growing and distributing medical cannabis) is, in practice, an underestimate. A more accurate assessment would acknowledge that this process most typically takes 'many years' from start to completion.

Further, it is my opinion that Mr. Mikos underemphasizes the significance of this time lag and the potential adverse consequences it may have upon patients whose health conditions require immediate access to legal, medicinal cannabis. It is hard to imagine that many patients would argue that commercial cultivation is "superior" to personal cultivation in these instances where commercial cultivation has failed, in any tangible way, to address patients' immediate needs for legal cannabis access. In fact, because of this inherent time lag, some patients who might otherwise benefit from their own state's proposed medical cannabis programs have reportedly relocated to states that allow for home cultivation (e.g., Colorado) rather than to wait until their own state programs are fully operational.

Further, commercial cultivation schemes such as those favored by Mr. Mikos arguably result in a more expensive cannabis product because producers face significant up front costs and fees in order to apply for and obtain state licensing. (For example, in Illinois it has been reported that the state is charging a $25,000 application fee and a $200,000 permit fee for grow centers, while those who wish to open a dispensary must pay a $5,000 application fee and have $400,000 in liquid assets. Several other jurisdictions impose similar regulatory fees, resulting in inflated market prices.) These start up costs are ultimately passed on to the medical marijuana consumer and arguably limit the ability of indigent patients to access the product legally through state-licensed channels. In California, many cities that allow for the distribution of medical cannabis impose a local 'sin tax' of between 10 and 15 percent on medical cannabis sales, yet another added fee that is passed on to the medical consumer and one that may further limit patients' access.

Further, Mr. Mikos' supposition that non-commercial cultivation grow sites "have become lucrative targets for theft and violence due to excess cash on hand" is not supported by the scientific literature. Specifically, a 2014 study published in the journal *PLoS One* tracked crime rates across all 50 states between the years 1990 and 2006, a time period during which 11 states legalized marijuana for medical use. It concluded, "The central finding gleaned from the present study was that MML (medical marijuana legalization) is not predictive of higher crime rates and may be related to reductions in rates of homicide and assault,

... Interestingly, robbery and burglary rates were unaffected by medicinal marijuana legislation, which runs counter to the claim that dispensaries and grow houses lead to an increase in victimization due to the opportunity structures linked to the amount of drugs and cash that are present." Further, since existing US federal banking regulations discourage financial institutions from engaging in relationships with cannabis-specific enterprises, including state-licensed medical cannabis producers or distributors, the imposition of state laws mandating commercial facilities while prohibiting personal cultivation would not, at this time, sufficiently address Mr. Mikos' theoretical concern.

Finally, it should be acknowledged that, to date, no state that permits patients to cultivate their own medical marijuana has ever taken legislative action to eliminate this legal right. By contrast, some states lawmakers have taken action to increase the plant limits (e.g., Oregon) allowed by statute so that they may be in greater accordance with patients' personal needs. This reality would appear to substantiate the notion that home cultivation laws are operating primarily as intended, are seldom abused, and remain popular among the patient community, lawmakers, and the general public.

In conclusion, it is my opinion that Ms. Mehler's statement, "Nearly all jurisdictions that prohibit personal cultivation create alternative means of accessing medical marijuana" is, in practice, illusionary since qualified patients in a majority of these states, at present, do not possess legal access to medicinal cannabis products and will continue to lack access in the foreseeable future. Moreover, Ms. Mehler's conclusion, "[A]n overwhelming majority of states that do not permit patients to manufacture marijuana, have developed programs, including the registration of licensed manufacturers and dispensaries, to facilitate access to medical marijuana by patients and their caregivers" appears to be inaccurate because the majority of these proposed programs remain, at this time, non-operational. Finally, it is my opinion that Mr. Mikos' suppositions in regard to the "superiority" of commercial cultivation schemes downplays the inherent challenges and limitations faced by qualified patients who may find their access to medical cannabis limited or non-existent in states that mandate such regulations.

(*g*) the reasons for each opinion expressed;

See above in relation to each point in the reports of Ms. Mehler and Mr. Mikos

(*h*) any literature or other materials specifically relied on in support of the opinions;

State summaries of medical marijuana laws. Online document appearing on the NORML website. Accessed December 9, 2014.
<http://norml.org/legal/medical-marijuana-2> Attached as Schedule "B"

Christopher Snowbeck. Minnesota legislature reaches deal on medical marijuana. *Twin Cities (Minnesota) Pioneer Press*, May 16, 2014
http://www.twincities.com/politics/ci_25768621/minnesota-medical-marijuana-deal-reached-legislature

Teri Weaver. NY medical marijuana program to ban smoking, sunset in 7 years. Syracuse.com (New York), June 19, 2014.
<http://www.syracuse.com/news/index.ssf/2014/06/ny_medical_marijuana_program_to_exclude_smoking_sunset_in_7_years.html>

Rachel Koff. Judge rejects lottery for medical marijuana growers; orders health department to write new rules, *Tampa Bay (Florida) Times*, November 14, 2014.
<http://www.tampabay.com/blogs/the-buzz-florida-politics/judge-orders-health-department-to-redraw-medical-marijuana-rules/2206556>

Paul Armentano. Patients still have no access to CBD cannabis medicine in 'CBD-only' states. Alternet.org, September 3, 2014.
<http://www.alternet.org/drugs/patients-still-have-no-access-cbd-cannabis-medicine-cbd-only-states-0>

Gregory Hall. Marijuana oil for treating seizures faces hurdles. *Louisville Courier-Journal* (Kentucky), May 13, 2014.
<http://www.usatoday.com/story/news/nation/2014/05/13/marijuana-oil-for-treating-seizures-faces-hurdles/9058013/>

Jimmie Gates. Marijuana oil for medical treatment not happening until 2015. *The Clarion-Ledger* (Mississippi), September 4, 2015.
<http://www.clarionledger.com/story/news/2014/09/03/marijuana-oil-medical-treatment-least-year-away/15034907/>

Dana Ferguson. Law allowing marijuana derivative for treatment of seizures remains unused. *Milwaukee (Wisconsin) Journal Sentinel*, June 16, 2014.
<http://www.jsonline.com/news/statepolitics/law-allowing-marijuana-derivative-for-treatment-of-seizures-remains-unused-b99289174z1-263233521.html>

Michelle Price. 11 cards issued in Utah cannabis oil program. The Spectrum, August 9, 2014.
<http://www.thespectrum.com/story/news/local/2014/08/09/cards-issued-utah-cannabis-oil-program/13846611/>

Tony Leys. Cannabis oil 'light years away' for Iowa families. *The Des Moines (Iowa) Register*, August 26, 2014.
<http://www.desmoinesregister.com/story/news/health/2014/08/26/medical-marijuana-light-years-iowa-for-iowans-with-epilepsy/14634181/>

Kirk Brown. Flaws found in new South Carolina laws for hemp production and cannabis extracts. *Independent Mail* (South Carolina), September 3, 2014. <http://www.independentmail.com/news/flaws-found-in-new-sc-laws-for-hemp-production-and-cannabis-extract_57438645>

Kenneth Gosselin and Matthew Sturdevant. Medical marijuana sales begin after long wait. *Hartford (Connecticut) Courant*, September 22, 2014. <http://touch.courant.com/#section/-1/article/p2p-81449162/>

Ben Leubsdorf. Medical marijuana now legal in New Hampshire, but rule-writing means delay for patients, dispensaries. *Concord (New Hampshire) Monitor*, August 4, 2013. <http://www.concordmonitor.com/news/7867228-95/medical-marijuana-now-legal-in-nh-but-rule-writing-means-delay-for-patients-dispensaries>

Susan Livio. New Jersey medical marijuana program struggling, with worries growing over few doctors, patients enrolled. *Star Ledger* (New Jersey), June 15, 2014. <http://www.nj.com/politics/index.ssf/2014/06/medical_marijuana_programs_slow_enrollment_worries.html>

Mark Eichmann. Delaware medical marijuana patients in limbo. June 21, 2013. Newsworks.org. <http://www.newsworks.org/index.php/local/delaware/56405-delaware-medical-marijuana-patients-in-limbo>

Nicholas Handy. Massachusetts advocates outraged over further marijuana dispensary delays. Worchester.com (Massachusetts), August 18, 2014. <http://www.golocalworcester.com/news/ma-advocates-outraged-over-further-marijuana-dispensary-delays>

Kelli Grant. Marijuana refugees: looking for a new home in pot-legal states. NBC News, February 5, 2014. <http://www.nbcnews.com/business/consumer/marijuana-refugees-looking-new-homes-pot-legal-states-n22781>

Robert McCoppin. Medical marijuana may cost patients top dollar. *Chicago (Illinois) Tribune*, September 1, 2014. <http://my.chicagotribune.com/#section/-1/article/p2p-81237658/>

Michael DeBonis. DC medical marijuana: is it worth the price? *Washington Post*, July 31, 2013. <http://www.washingtonpost.com/blogs/mike-debonis/wp/2013/07/31/d-c-medical-marijuana-is-it-worth-the-price/>

Associated Press. California measures taxing medical marijuana win big at ballot box. November 5, 2014. <http://sacramento.cbslocal.com/2014/11/05/california-measures-taxing-medical-marijuana-win-big-at-ballot-box/>

Morris et al. 2014. The effect of medical marijuana laws on crime: evidence from state panel data, 1990-2006. PLOS One, March 26, 2014. <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0092816>

Steven Rosenberg. Banks shy away from medical marijuana businesses. Boston Globe, August 10, 2014. <http://www.bostonglobe.com/metro/regionals/north/2014/08/09/marijuana-dispensaries-will-cash-businesses-unless-banks-let-them-customers/d8rSbyZcEwYBxC4WJT76cP/story.html>

Noelle Crombie. Legal marijuana in Oregon: a look at the state's pot history. Oregonlive.com, November 7, 2014. <http://www.oregonlive.com/marijuana/index.ssf/2014/11/legal_marijuana_in_oregon_a_lo.html>

(*i*) a summary of the methodology used, including any examinations, tests or other investigations on which the expert has relied, including details of the qualifications of the person who carried them out, and whether a representative of any other party was present;

N/A

(*j*) any caveats or qualifications necessary to render the report complete and accurate, including those relating to any insufficiency of data or research and an indication of any matters that fall outside the expert's field of expertise; and

I am not a lawyer nor am I an economist.

(*k*) particulars of any aspect of the expert's relationship with a party to the proceeding or the subject matter of his or her proposed evidence that might affect his or her duty to the Court.

I do not have any relationship to any party to the proceedings and my knowledge or relationship of the subject matter of my proposed evidence will not affect my duty to the court.

Schedule "A"

PAUL ARMENTANO

Professional Experience

- Deputy Director, National Organization for the Reform of Marijuana Laws 1995-1999, 2001-present

Relevant Peer-Reviewed Publications

- Armentano. 2010. Driving Under the Influence. In: Holland. The Pot Book: A Complete Guide to Cannabis, Its Role in Medicine, Politics, Science, and Culture. Toronto: Park Street Press. pp. 196-201.

- Armentano. 2012. Cannabis and Psychomotor Performance: A Rational Review of the Evidence and Implications for Public Policy. *Drug Testing & Analysis,* Volume 5, Issue 1, pp. 52-56.

- Armentano, 2013. Should Per Se Limits Be Imposed For Cannabis? Equating Cannabinoid Blood Concentrations With Actual Driver Impairment: Practical Limitations and Concerns. *Humboldt Journal of Social Relations*, Issue 35, pp. 41-51.

- Armentano. 2015 (in press). Are THC concentrations appropriate for presuming psychomotor impairment? In. Tiftickjian. Colorado Marijuana: The Law and Practice. Tucson: Lawyers & Judges Publishing Company.

Books

- Co-author. Marijuana Is Safer: So Why Are We Driving People to Drink? (2009, revised 2013) White River Junction, VT: Chelsea Green Press

- Emerging Clinical Applications For Cannabis and Cannabinoids: A Review of the Recent Scientific Literature (2008, revised 2012) Washington, DC: NORML Foundation

Chapters (partial list)

Mr. Armentano has authored chapters pertaining to the subject of cannabis, the law, health implications, and public policy for nearly two-dozen anthologies and textbooks, including: Think: Critical Thinking and Logic Skills For Everyday Life (McGraw Hill, 2011); Marijuana (Thomson Gale/Cengage Learning, 2009); Gateway Drugs (Thomson Gale/Cengage Learning, 2008); Introducing Issues With Opposing Viewpoints: Marijuana (Thomson Gale/Cengage Learning, 2007); Drugs, Society & Behavior -- 20th Edition (McGraw Hill, 2005); The War on Drugs: Opposing Viewpoints (Thomson Gale/Cengage Learning, 2004); You Are Being Lied To: The Disinformation Guide to

Media Distortion, Historical Whitewashes and Cultural Myths (Disinformation Press, 2001); and Drug Abuse: Opposing Viewpoints (Greenhaven Press, 1999)

Relevant Presentations (partial list)

- Plenary speaker. At: Symposium on Medical Cannabis Therapeutics, Lebanon, NH, 2014. Sponsored by Dartmouth University and the Dartmouth-Hitchcock Medical School. **CME-accredited event, CNE-accredited event**

- Principle Investigator. Evidentiary hearing: *US v Pickard* et al. US federal court, Eastern District of California, Sacramento: October 25-30, 2014.

- Plenary Speaker. At: California DUI Lawyers Association 2014 Conference: DUI-D and DRE, Fresno, CA. **MCLE-accredited event**

- Oral and Written Testimony before the Nevada Advisory Commission of the Administration of Justice's Subcommittee on Medical Use of Marijuana, Las Vegas, NV: August 21, 2014

- Faculty member and plenary speaker. At: Eighth National Clinical Conference on Cannabis Therapeutics, Portland, OR, 2014. Sponsored by Patients Out of Time and the University of California at San Francisco School of Medicine. **CME-accredited event**

- Plenary Speaker. At: Eighth National Clinical Conference on Cannabis Therapeutics, Pre-Conference Workshop, Portland, OR, 2014. **CLE-accredited event**

- Plenary Speaker. At: California DUI Lawyers Association 2014 Conference: DUI Drugs in the State Capitol, Sacramento, CA. **CLE-accredited event**

- Plenary Speaker. "Equating Cannabinoid Concentrations With Psychomotor Impairment: Limitations and Concerns." At: DUI Drug Cases & DRE: Mastering the Science & Trial Skills, Denver, CO, 2013. Sponsored by International Legal & Forensic Science Services

- Plenary Speaker. At: Colorado Criminal Defense Bar 2013 DUI Conference, Breckenridge, CO, 2013. Sponsored by the Colorado Criminal Defense Bar

- Oral Testimony before the Washington state House of Representatives, House Committee on Public Safety, Olympia, Washington: February 6, 2013.

- Plenary Speaker. At: California Association of Toxicologists Spring 2012 Meeting, San Jose, 2012. Sponsored by the California Association of Toxicologists

- Plenary Speaker. At: Café Conversation. Sponsored by the Chabot Space and Science Center. Oakland, CA.

- Plenary Speaker. At: DUID Marijuana Per se Working Group/Drug Policy Task Force, Denver, CO, 2011. Sponsored by the Colorado Commission on Criminal and Juvenile Justice

- Plenary Speaker. At: 40th Annual Convention of the National Association of School Psychologists, New Orleans, LA, 2008.

- Plenary Speaker. At: Fifth National Clinical Conference on Cannabis Therapeutics, Pacific Grover, CA. Sponsored by Patients Out of Time and the University of California at San Francisco School of Medicine. **CME-accredited event**

Training Seminars:

- Special Session: Driving Under the Influence of Drugs. Washington, DC, 2008. Sponsored by: American Academy of Forensic Sciences (AAFS).

- 34th Annual Meeting of the Society of Forensic Toxicologists. Nashville, TN, 2005. Sponsored by SOFT.

- Developing Global Strategies for Identifying, Prosecuting, and Treating Drug-Impaired Drivers, Tampa, FL, 2004. Sponsored by: The Counterdrug Technology Assessment Center (CTAC) at the Office of National Drug Control Policy; Cosponsored by: The International Association of Forensic Toxicologists (TIAFT), the International Council on Alcohol, Drugs, and Traffic Safety (ICADTS), and the National Institute on Drug Abuse (NIDA).

Education

- Bachelor of Arts, Political Science
  Saint Bonaventure University, 1994
  Graduated cum laud

Honors

- 2013 recipient: The Alfred R. Lindesmith Award for Achievement in the Field of Scholarship

- 2013 recipient: Freedom Law School Health Freedom Champion of the Year award

- 2008 recipient: Project Censored Real News Award for Outstanding Investigative Journalism

Additional Qualifications

- Mr. Armentano has reviewed, summarized, and commented upon thousands of academic studies and white papers pertinent to cannabis use, its pharmacokinetics, and its impact on behavior.

- Mar. Armentano has presented oral and/or written testimony in regard to cannabis policy before various state legislatures and also federal agencies.

- Mr. Armentano is a nationally and internationally recognized expert on the subject of cannabis, the law, the plant's health implications, and public policy. His writing has appeared in over 750 publications, including *The New York Times*, *The Los Angeles Times,* and *Congressional Quarterly, Cato Unbound,* as well as in scholarly journals. He has appeared in interviews for hundreds of national and international media outlets, including MSNBC, the BBC, Fox News, and Al Jazeera.

- Mr. Armentano is one of the most quoted experts in the United States in the national media regarding the issue of cannabis and public policy, having been quoted as an authority in hundreds of media in forums such as *The New York Times, The Los Angeles Times*, *Scientific American*, *Congressional Quarterly*, and *National Public Radio.*

- Mr. Armentano provides online content to TheAnswerPage.com, an online medical educational resource founded in 1998 that provides daily education to healthcare professionals in 120 countries, as well as CME credit.

- Mr. Armentano is the primary content provider for the NORML.org website, one of the most trafficked marijuana content sites in the United States, where he summarizes new developments specific to cannabis, its health effects, and its legal status.

- Mr. Armentano serves of the faculty of Oaksterdam University in Oakland, CA where he lectures on issues specific to the comparative safety and relative efficacy of cannabis and cannabinoids as therapeutic agents.

- Mr. Armentano has offered legal consultation in dozens of criminal cases involving issues pertaining to the science of cannabis and/or cannabis policy.

Schedule "B"

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Alaska Medical Marijuana

SUMMARY: Fifty-eight percent of voters approved Ballot Measure #8 on November 3, 1998. The law took effect on March 4, 1999. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician advising that they "might benefit from the medical use of marijuana." Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*, *chronic pain*; *epilepsy and other disorders characterized by seizures*; *glaucoma*; *HIV or AIDS*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea*. Other conditions are subject to approval by the Alaska Department of Health and Social Services. Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients.

The medical use provisions in Alaska do not include reciprocity provisions protecting visitors from other medical use states.

AMENDMENTS: Yes.

Senate Bill 94, which took effect on June 2, 1999, mandates all patients seeking legal protection under this act to enroll in the state patient registry and possess a valid identification card. Patients not enrolled in the registry will no longer be able to argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

MEDICAL MARIJUANA STATUTES: Alaska Stat. §§ 17.37.10 - 17.37.80 (2007).

CAREGIVERS: Yes. The caregiver must be 21 years of age or older. The caregiver can never have been convicted of a felony controlled substances offense. The caregiver must be listed by the patient as either the primary caregiver or an alternate caregiver. Only one primary caregiver and one alternate caregiver may be listed in the registry for a patient. A person may be a primary caregiver or alternate caregiver for only one patient at a time, unless the primary caregiver or alternate caregiver is simultaneously caring for two or more patients who are related to the caregiver by at least the fourth degree of kinship by blood or marriage. Alaska Stat. §17.37.010 (2007).

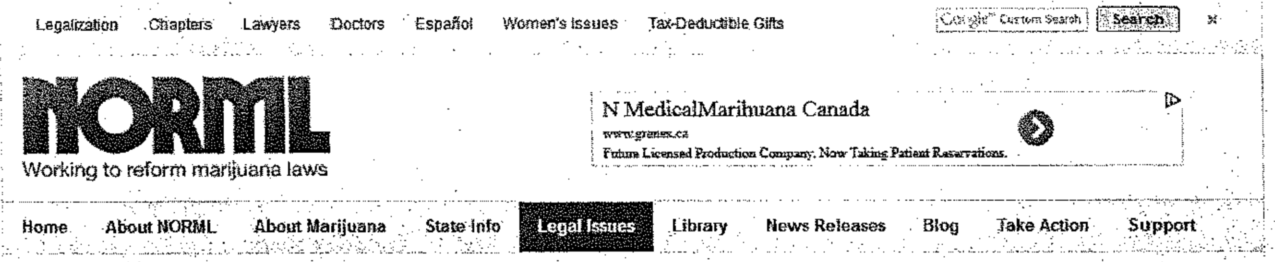
CONTACT INFORMATION: For more information on Alaska's medical marijuana law, please contact:

Schedule "B"

Alaskans for Medical Rights
P.O. Box 102320
Anchorage, AK 99510
(907) 277-AKMR (2567)

Application information for the Alaska medical marijuana registry is available by writing or calling:

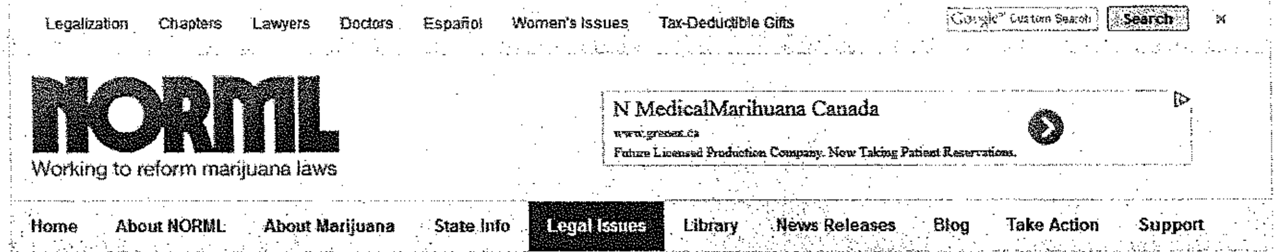
Alaska Department of Health and Social Services
P.O. Box 110699
Juneau, AK 99811-0699
(907) 465-5423
Attention: Terry Ahrens
terry_ahrens@health.state.ak.us



Arizona Medical Marijuana

SUMMARY: Just over 50 percent of voters (50.13 percent) approved Proposition 203 on November 2, 2010. The law removes state-level criminal penalties on the use and possession of marijuana by patients who have "written certification" from their physician that marijuana may alleviate his or her condition. The law took effect on April 14, 2011. Patients diagnosed with the following illnesses are afforded legal protection under this act: *cancer; glaucoma; positive status for HIV or AIDS, hepatitis C, amyotrophic lateral sclerosis (Lou Gehrig's disease), Crohn's disease, agitation of Alzheimer's disease* or any chronic or debilitating medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, including those characteristic of epilepsy, severe or persistent muscle spasms, including those characteristic of multiple sclerosis, persistent muscle spasms or seizures, severe nausea or pain. Other conditions will be subject to approval by the Arizona Department of Health Services. Patients (or their primary caregivers) may legally possess no more than two and one-half ounces of usable marijuana, and may cultivate no more than twelve marijuana plants in an "enclosed, locked facility." The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. State-licensed nonprofit dispensaries may produce and dispense marijuana to authorized patients on a not-for-profit basis. Qualified patients who reside within 25 miles of a state-licensed dispensary facility will not be permitted to cultivate marijuana at home. Final rules for the program, physician certification forms, and a frequently asked questions (FAQs) page are all available online at the website of the Arizona Medical Marijuana Program here. http://www.azdhs.gov/prop203/

RECIPROCITY: Yes. The act defines a 'visiting qualifying patient' as a person 'who has been diagnosed with a debilitating medical condition by a person who is licensed with authority to prescribe drugs to humans in the state of the person's residence.'



California Medical Marijuana

SUMMARY: Fifty-six percent of voters approved Proposition 215 on November 5, 1996. The law took effect the following day. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a "written or oral recommendation" from their physician that he or she "would benefit from medical marijuana." Patients diagnosed with any debilitating illness where the medical use of marijuana has been "deemed appropriate and has been recommended by a physician" are afforded legal protection under this act. Conditions typically covered by the law include but are not limited to: *arthritis*; *cachexia*; *cancer*; *chronic pain*; *HIV or AIDS*; *epilepsy*; *migraine*; and *multiple sclerosis*. No set limits regarding the amount of marijuana patients may possess and/or cultivate were provided by this act, though the California Legislature adopted guidelines in 2003.

The medical use provisions in California do not include reciprocity provisions protecting visitors from other medical use states.

AMENDMENTS: Yes. Senate Bill 420, which was signed into law in October 2003 and took effect on January 1, 2004, imposes statewide guidelines outlining how much medicinal marijuana patients may grow and possess. Under the guidelines, qualified patients and/or their primary caregivers may possess no more than eight ounces of dried marijuana and/or six mature (or 12 immature) marijuana plants. However, S.B. 420 allows patients to possess larger amounts of marijuana when such quantities are recommended by a physician. The legislation also allows counties and municipalities to approve and/or maintain local ordinances permitting patients to possess larger quantities of medicinal pot than allowed under the new state guidelines.

Senate Bill 420 also mandates the California Department of State Health Services to establish a voluntary medicinal marijuana patient registry, and issue identification cards to qualified patients. To date, however, no such registry has been established.

Senate Bill 420 also grants implied legal protection to the state's medicinal marijuana dispensaries, stating, "Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients ... who associate within the state of California in order collectively or cooperatively to cultivate marijuana for medical

purposes, shall not solely on the basis of that fact be subject to state criminal sanctions."

MEDICAL MARIJUANA STATUTES: California Compassionate Use Act 1996, Cal. Health & Saf. Code, § 11362.5 (1996) (codifying voter initiative Prop. 215).

Cal. Health & Saf. Code, §§ 11362.7 - 11362.83 (2003) (codifying SB 420).

CAREGIVERS: Yes. Primary caregiver is 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. The caregiver must be 18 years of age or older (unless the primary caregiver is the parent of a minor child who is a qualified patient or a person with an identification card). Cal. Health & Saf. Code, §11362.7 (2003).

CONTACT INFORMATION: For more information on California's medical marijuana law, please contact:

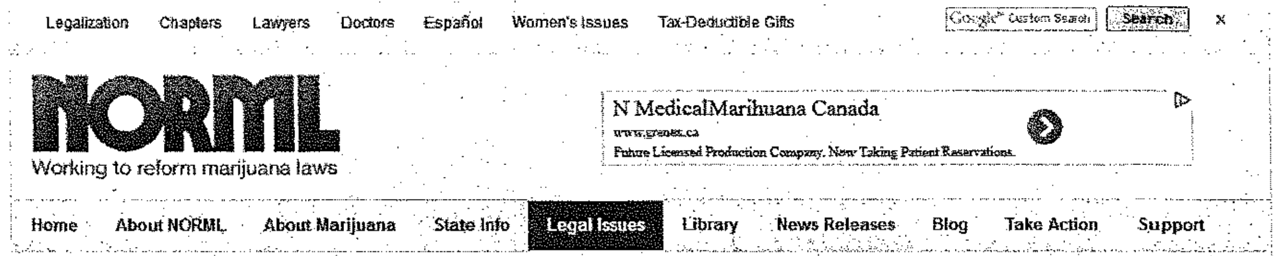
California NORML
2261 Market Street #278A
San Francisco, CA 94144
(415) 563-5858
http://www.canorml.org/

For detailed information on county or municipal medical marijuana guidelines, please visit: http://www.canorml.org/medical-marijuana/local-growing-limits-in-California

For a list of California doctors who recommend medical cannabis, please visit: http://listings.canorml.org/medical-marijuana-doctors-in-California/list.lasso

For a list of California medical cannabis providers, please visit: http://canorml.org/medical-marijuana/California-collectives-and-dispensaries-guide

Schedule "B"



Colorado Medical Marijuana

SUMMARY: Fifty-four percent of voters approved Amendment 20 on November 7, 2000, which amends the state's constitution to recognize the medical use of marijuana. The law took effect on June 1, 2001. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician affirming that he or she suffers from a debilitating condition and advising that they "might benefit from the medical use of marijuana." (Patients must possess this documentation prior to an arrest.) Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*, *chronic pain*; *chronic nervous system disorders*; *epilepsy and other disorders characterized by seizures*; *glaucoma*; *HIV or AIDS*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea*. Other conditions are subject to approval by the Colorado Board of Health. Patients (or their primary caregivers) may legally possess no more than two ounces of usable marijuana, and may cultivate no more than six marijuana plants. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

The medical use provisions in Colorado do not include reciprocity provisions protecting visitors from other medical use states.

AMENDMENTS: Yes. House Bill 1284, signed into law on June 7, 2010, establishes state provisions regulating medical cannabis dispensaries. The law requires medical marijuana dispensing facilities to obtain state and local licensing approval and to be in compliance with all local zoning codes. Dispensaries must pay a state licensing fee, shall be located no closer than 1,000 feet from a school or daycare (municipalities have the authority to issue exemptions to this rule), and operators must oversee the cultivation at least 70 percent of the marijuana dispensed at the center. Licensed dispensary owners will be required to undergo criminal background checks by the state.

House Bill 1284 imposes a statewide moratorium on the establishment of new dispensaries, beginning in July 2010. HB 1284 also grants local municipalities the authority to prohibit the establishment of dispensaries in their community. Individual

caregivers are legally permitted to provide medical cannabis for up to five patients in localities that have formally banned dispensaries.

Full text of the law is available here.

ADDITIONAL AMENDMENTS: Yes. Senate Bill 109, signed into law on June 7, 2010, limits the authority of physicians to recommend cannabis therapy to patients with which the doctor has had a prior counseling relationship.

Full text of the law is available here.

MEDICAL MARIJUANA STATUTES: C.O. Const. art. XVIII, §14 (2001) (codified as §0-4-287 art. XVIII).

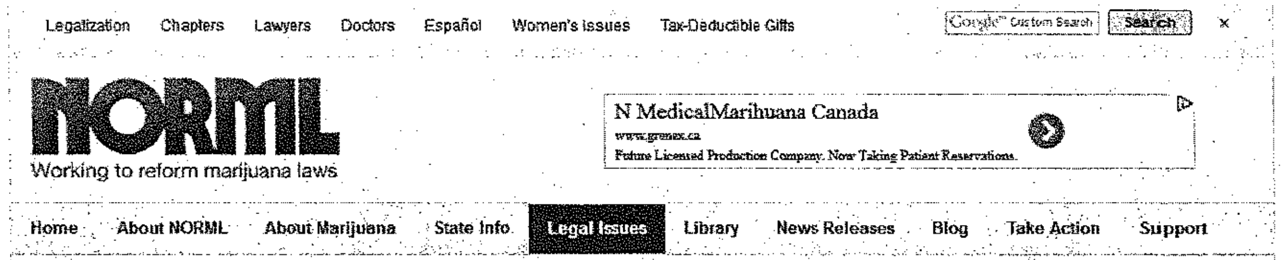
Colo. Rev. Stat. § 18-18-406.3 (2001) (interpreting the provisions of the ballot initiative and constitutional amendment).

Colo. Rev. Stat. § 25-1.5-106 (2003) (originally enacted as § 25-1-107(1)(jj) (2001)) (describing the powers and duties of the Colorado Department of Public Health).

CAREGIVERS: Yes. Primary caregiver is a person other than the patient or the patient's physician. The caregiver must be 18 years of age or older. A patient can only have one primary caregiver at a time. A patient who has designated a primary caregiver for himself or herself may not be designated as a primary caregiver for another patient. A primary caregiver may be listed on the medical marijuana registry for no more than 5 patients. Colo. Rev. Stat. §25-1.5-106 (2), (10) (2001).

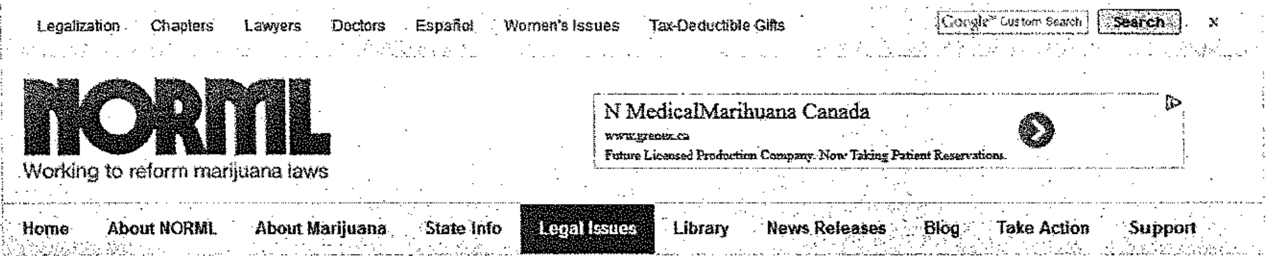
CONTACT INFORMATION: Application information for the Colorado medical marijuana registry is available online or by writing:

Colorado Department of Public Health and Environment
HSVR-ADM2-A1
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Phone: 303-692-2184
http://www.cdphe.state.co.us/hs/medicalmarijuana/fullpacket.pdf



Delaware Medical Marijuana

SUMMARY: Governor Jack Markell signed legislation -- Senate Bill 17, The Delaware Medical Marijuana Act -- into law on May 13, 2011. State regulators have up to one-year to draft regulations to formally govern the program. The law removes state-level criminal penalties on the use and possession of cannabis obtained from state-licensed facilities for patients with an authorized "debilitating medical condition." The measure provides for the establishment of at least one non-profit 'compassion center' per county that would be licensed by the state to produce and dispense medical cannabis. Recommending physicians must have "bona fide physician-patient relationship" with a person before recommending the use of medical cannabis. Medical conditions that may qualify for cannabis under this act include: *cancer, HIV/AIDS, amyotrophic lateral sclerosis, Alzheimer's disease*, and *post-traumatic stress disorder,* as well as *cachexia, chronic pain* (if the condition has not responded to previously prescribed medications), severe *nausea, seizures* or *severe and persistent muscle spasms*, including but not limited to those characteristic of *multiple sclerosis*. Patients may legally possess up to 6 ounces of usable marijuana, if the marijuana is obtained from a state-licensed facility. Home cultivation of marijuana is not allowed under this act. The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients. The act also provides medical marijuana patients who are not registered with the state to raise an 'affirmative defense' motion to dismiss at trial. This act includes reciprocity provisions protecting visitors from other medical use states.



District of Columbia Medical Marijuana

SUMMARY: D.C. Council Members enacted legislation in May 2010 authorizing the establishment of regulated medical marijuana dispensaries in the District of Columbia. On Monday, July 26, members of Congress allowed the measure to become law without federal interference.

The law amends the Legalization of Marijuana for Medical Treatment Initiative, a 1998 municipal ballot measure which garnered 69 percent of the vote yet was never implemented. Until 2010, D.C. city lawmakers had been barred from instituting the measure because of a Congressional ban on the issue. Congress finally lifted the ban in 2009.

Under the law, D.C. Health Department officials will oversee the creation of as many as eight facilities to dispense medical cannabis to authorized patients. Medical dispensaries would be limited to growing no more than 95 plants on site at any one time.

Both non-profit and for-profit organizations will be eligible to operate the dispensaries.

Qualifying D.C. patients will be able to obtain medical cannabis at these facilities, but will not be permitted under the law to grow their own medicine. Patients diagnosed with the following illnesses are afforded legal protection under this act: *HIV or AIDS; glaucoma; conditions characterized by severe and persistent muscle spasms, such as multiple sclerosis; cancer; or any other condition, as determined by rulemaking, that is: "(i) chronic or long-lasting; "(ii) debilitating or interferes with the basic functions of life; and (iii) A serious medical condition for which the use of medical marijuana is beneficial: (I) That cannot be effectively treated by any ordinary medical or surgical measure; "(II) For which there is scientific evidence that the use of medical marijuana is likely to be significantly less addictive than the ordinary medical treatment for that condition.* The maximum amount of medical marijuana that any qualifying patient may possess at any moment is 2 ounces of dried medical marijuana, though this limit is subject to revision by the Mayor.

A separate provision enacted as part of the 2011 D.C. budget calls for the retail sales of medical cannabis to be subject to the District's six percent sales tax rate. Low-income will be allowed to purchase medical marijuana at a greatly reduced cost under the plan.

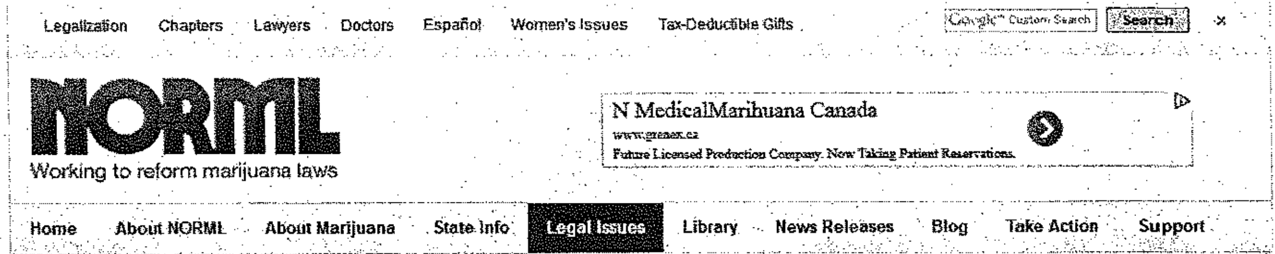
It will likely be several months before Health officials establish a patient registry and/or begin accepting applications from the public to operate the City's medical marijuana production and distribution centers.

The medical use provisions in the District of Columbia do not include reciprocity provisions protecting visitors from other medical use states.

CAREGIVERS: Yes. Caregiver is a person designated by a qualifying patient as the person authorized to possess, obtain from a dispensary, dispense, and assist in the administration of medical marijuana. The caregiver must be 18 years of age or older. The caregiver must be registered with the Department as the qualifying patient's caregiver. A caregiver may only serve one qualifying patient at a time. D.C. Act 13-138 §2 (3) (2010).

CONTACT INFORMATION: DC City Council Committee on Health or DC Department of Health

Schedule "B"



Hawaii Medical Marijuana

SUMMARY: Governor Ben Cayetano signed Senate Bill 862 into law on June 14, 2000. The law took effect on December 28, 2000. The law removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed statement from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of medical use of marijuana would likely outweigh the health risks." Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*, *chronic pain*; *Crohn's disease*; *epilepsy and other disorders characterized by seizures*; *glaucoma*; *HIV or AIDS*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea*. Other conditions are subject to approval by the Hawaii Department of Health. Patients (or their primary caregivers) may legally possess up to 3 ounces of usable marijuana, and may cultivate no more than seven marijuana plants, of which no more than three may be mature. The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients.

The medical use provisions in Hawaii do not include reciprocity provisions protecting visitors from other medical use states.

AMENDMENTS: No, although Hawaii has a separate statute allowing patients arrested on marijuana charges to present a "choice of evils" defense arguing that their use of marijuana is medically necessary.

MEDICAL MARIJUANA STATUTES: Haw. Rev. Stat. §§ 329-121 to 329-128 (2008).

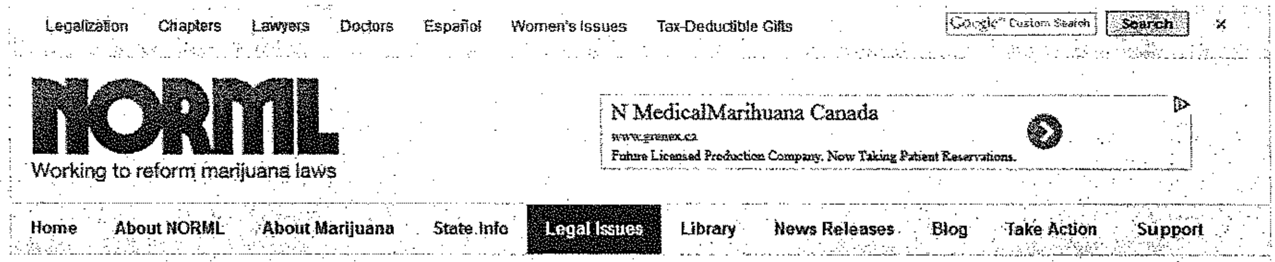
CAREGIVERS: Yes. Primary caregiver is a person who has the responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana. Primary caregiver is a person other than the qualifying patient, or the patient's physician. The caregiver must be 18 years of age or older. Qualifying patients shall have only one primary caregiver an any given time. Primary caregiver shall be responsible for the care of only one qualifying patient at any given time. Haw. Rev. Stat. §§329-121; 329-123 (b),(c) (2008).

Schedule "B"

CONTACT INFORMATION: Administrative rules for Hawaii's medical marijuana program are available online from the Drug Policy Forum of Hawaii website at: http://www.dpfhi.org/

Application information for the Hawaii medical marijuana registry is available by writing or calling:

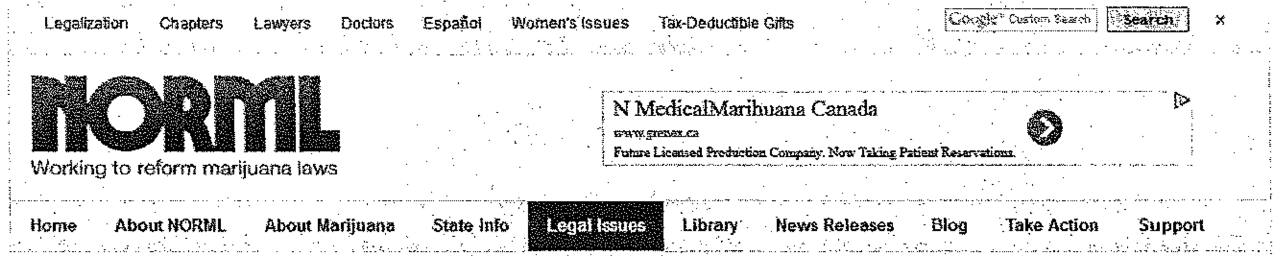
Hawaii Department of Public Safety
919 Ala Moana Boulevard
Honolulu, HI 96814
(808) 594-0150



Illinois Medical Marijuana

SUMMARY: Democratic Gov. Pat Quinn on August 1, 2013 signed legislation, House Bill 1, making Illinois the 20th state to authorize the physician-recommended use of cannabis for qualified patients. The new law establishes a statewide, four-year pilot program regulating the production, distribution, and possession of medical cannabis. The program creates up to 22 state-licensed cannabis cultivation centers and up to 60 state-licensed dispensaries. Qualified patients participating in the program must have a preexisting relationship with their physician prior to receiving a recommendation for cannabis therapy. Patients diagnosed with one of approximately 40 qualifying conditions — including cancer, hepatitis C, rheumatoid arthritis, HIV, multiple sclerosis, lupus, and Crohn's disease — will be permitted to legally possess up to 2.5 ounces of cannabis per 14-day period. Under the law, patients must obtain cannabis only from a state-licensed facility.

The law took effect on January 1, 2014. State regulators have 120-days following the bill's enactment to file program rules and regulations with the Joint Committee on Administrative Rules.



Maine Medical Marijuana

SUMMARY: Sixty-one percent of voters approved Question 2 on November 2, 1999. The law took effect on December 22, 1999. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess an oral or written "professional opinion" from their physician that he or she "might benefit from the medical use of marijuana." Patients diagnosed with the following illnesses are afforded legal protection under this act: *epilepsy and other disorders characterized by seizures*; *glaucoma*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea or vomiting as a result of AIDS or cancer chemotherapy*. Patients (or their primary caregivers) may legally possess no more than two and one-half ounces of usable marijuana, and may possess no more than six "mature" marijuana plants. Qualified patients may additionally possess "harvested marijuana in varying stages of processing in order to ensure the patient is able to maintain supply and meet personal needs." Those patients who possess greater amounts of marijuana than allowed by law are afforded a "simple defense" to a charge of marijuana possession. The law does not establish a state-run patient registry.

RECIPROCITY: Yes. Authorizes visiting qualifying patient with valid registry identification card (or its equivalent), to engage in conduct authorized for the registered patient (the medical use of marijuana) for 30 days after entering the State, without having to obtain a Maine registry identification card. Visiting qualifying patients are not authorized to obtain in Maine marijuana for medical use. Me. Rev. Stat. Tit. 22, §2423-D (2010).

AMENDMENTS: Yes. Senate Bill 611, which was signed into law on April 2, 2002, increases the amount of useable marijuana a person may possess from one and one-quarter ounces to two and one-half ounces. Question 5, approved by 59 percent of voters on November 3, 2009, mandates the Department of Health to enact rules within 120 days establishing a confidential patient registry and identification card system, and allowing for the dispensing of medicinal cannabis via state-licensed nonprofit dispensaries. The act also expands the list of qualifying illnesses for which a physician may recommend medical cannabis to include: "A. cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, nail-

patella syndrome or the treatment of these conditions; B. a chronic or debilitating disease or medical condition or its treatment that produces intractable pain, which is pain that has not responded to ordinary medical or surgical measures for more than 6 months; C. a chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome; severe nausea; seizures, including but not limited to those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis; or D. any other medical condition or its treatment approved by the department as provided." Read the full text.

ADDITIONAL AMENDMENTS: Yes.

LD. 1811, signed into law on April 9, 2010, authorizes the creation of up to eight nonprofit medical cannabis dispensaries – one for each of the state's public health districts. Under the measure, dispensaries may legally "acquire, possess, cultivate, manufacture, deliver, transfer, transport, sell, supply or dispenses marijuana or related supplies and educational materials" to state-authorized medical marijuana patients. The Maine Department of Health and Human Services will oversee the licensing of these facilities.

The law also requires, for the first time, that authorized patients join a confidentially state registry. Cardholding patients will not be subject to "arrest, prosecution or penalty in any manner, including but not limited to a civil penalty or disciplinary action by any business or occupational or professional licensing board or bureau, or denied any right or privilege," for their possession, use, or cultivation of authorized amounts of medical cannabis (2 and one-half ounces and/or six plants).

Full text of the law is available here.

ADDITIONAL AMENDMENTS: Yes.

LD 1296, signed into law on July 24, 2011, eliminates the 2010 legislative mandate requiring medical marijuana patients to be registered with the state in order to receive legal protection under state law. It also eliminates language requiring physician's to disclose a patient's specific medical condition with the Maine Department of Health and Human Services. In addition, LD 1296 limits the ability of law enforcement to seize cannabis from lawful patients, and mandates for the return of any seized property within seven days. Finally, the law increased the amount of marijuana that may be legally possessed by qualifying patients from one and one-quarter ounces to two and one-half ounces, and additionally increased the number of mature marijuana plants a qualifying patient may cultivate at any one time from 3 to 6.

Full text of the measure is available here.

ADDITIONAL AMENDMENTS: Yes.

LD 1062 was enacted on June 26, 2013 and expands the list of qualifying conditions for which a Maine physician may legally recommend cannabis to include "post-traumatic

stress disorder," "inflammatory bowel disease" (such as Crohn's and/or ulcerative colitis), and "dyskinetic and spastic movement disorders and other diseases causing severe and persistent muscle spasms" (such as Parkinson's disease and/or Huntington's disease). The law took effect on September 28, 2013.

MEDICAL MARIJUANA STATUTES: Me. Rev. Stat. tit. 22, § 2383-B(5), (6) (1999) (amended 2001).

Me. Rev. Stat. tit. 22, § 2383-B(3)(e) (amended 2001) (increasing amount of marijuana a patient may posses to two and one-half ounces).

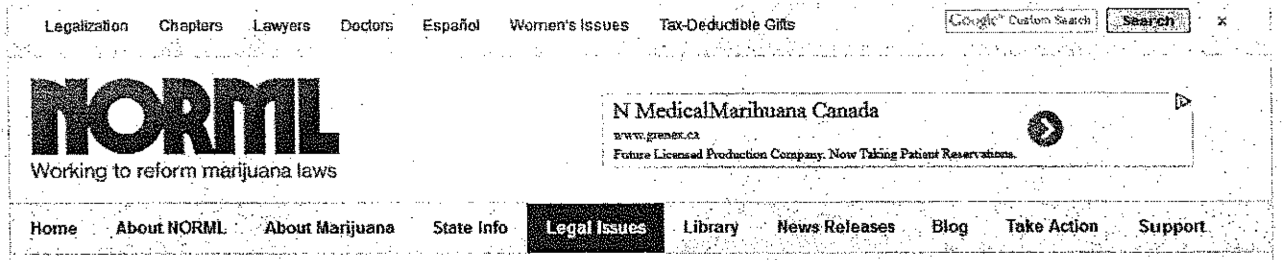
CAREGIVERS: Yes. Primary caregiver is a person providing care for the registered patient. The caregiver must be 21 years of age or older. The caregiver can never have been convicted of a disqualifying drug offense. Patients can name one or two primary caregivers. (only one person may be allowed to cultivate marijuana for a registered patient) Me. Rev. Stat. Tit. 22, §§2422; 2425 (2010).

STATE REGULATIONS: Statement of Maine's Medicinal Marijuana Law [PDF]

CONTACT INFORMATION: Brochures outlining Maine's medical marijuana law are available from:

www.mainecommonsense.org

Maine Citizens for Patients Rights
PO Box 1074
Lewiston, ME 04243



Maryland Medical Marijuana

SUMMARY: Maryland's legislature passed a medical marijuana affirmative defense law in 2003. This law requires the court to consider a defendant's use of medical marijuana to be a mitigating factor in marijuana-related state prosecution. If the patient, post-arrest, successfully makes the case at trial that his or her use of marijuana is one of medical necessity, then the maximum penalty allowed by law would be a $100 fine.

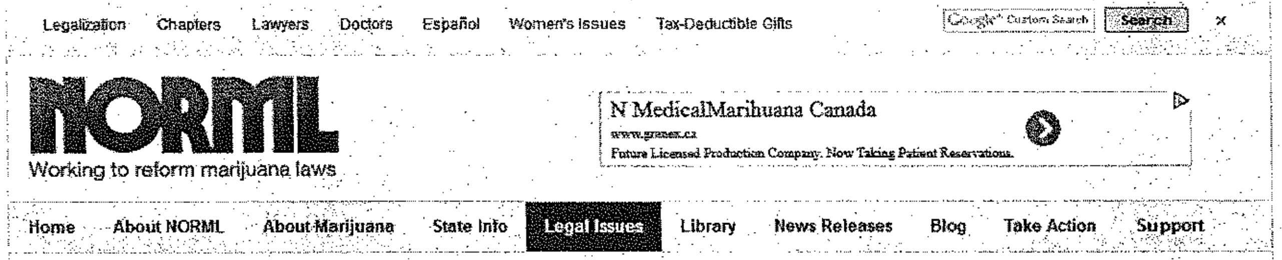
MEDICAL MARIJUANA STATUTES: Maryland Darrell Putman Compassionate Use Act, Md. Code Ann., Crim. Law §5-601(c)(3)(II) (2003).

AMENDMENTS: Yes.

Senate Bill 308, signed into law on May 10, 2011, removes fines and criminal penalties for citizens who successfully raise an 'affirmative defense' in court establishing that they possessed limited amounts (one ounce or less) of marijuana for medical purposes. Citizens who cultivate cannabis or who possess larger amounts of marijuana may still raise an affirmative defense at trial and, if successful, will have their sentence mitigated.

ADDITIONAL AMENDMENTS: Yes

House Bill 1101, signed into law on May 2, 2013, establishes an independent, 12-member medical marijuana commission within the state Department of Health. The commission will request applications from Maryland academic medical centers to operate 'medical marijuana compassionate use programs.' Members of the commission will decide which patients will qualify for the programs and will license growers to provide cannabis for therapeutic purposes. The law took effect on October 1, 2013. However, no state-sanctioned research programs are expected to be operational until 2015 or later.

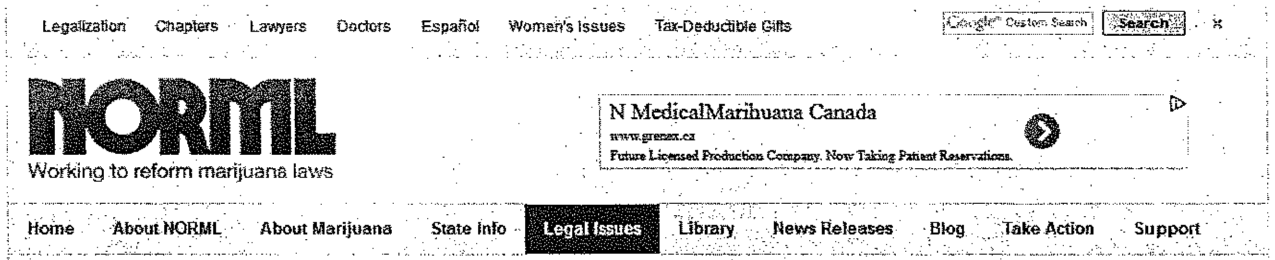


Massachusetts Medical Marijuana

SUMMARY: Sixty-three percent of voters approved Question 3 on November 6, 2012. The law took effect on January 1, 2013. It eliminates statewide criminal and civil penalties related to the possession and use of up to a 60-day supply of cannabis by qualified patients who possess a "valid registration card" issued by the state. ("Within 120 days of the effective date of this law, the department shall issue regulations defining the quantity of marijuana that could reasonably be presumed to be a sixty-day supply for qualifying patients.") Patients must possess a recommendation from a physician attesting that cannabis assists with the treatment of a "debilitating medical condition." Physicians may authorize cannabis for the treatment of "*cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis* and other conditions as determined in writing by a qualifying patient's physician." The law establishes a state-run patient registry and the creation of up to 35 state-licensed, non-profit "medical marijuana treatment centers." Within the first year after the law's implementation, the state must issue regulations for the creation of such centers. Individual patients will also be permitted to privately cultivate limited amounts of cannabis or designate a "personal caregiver" to cultivate for them if they are unable to access a state-authorized dispensary or if they can verify "financial hardship."

The medical use provisions in Massachusetts do not include reciprocity provisions protecting visitors from other medical use states.

Full text of the measure is available here. Additional information about the law is available from the Massachusetts Patient Advocacy Alliance.



Michigan Medical Marijuana

SUMMARY: Sixty-three percent of voters approved Proposal 1 on November 4, 2008. The law took effect on December 4, 2008. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physicians authorizing the medical use of marijuana. Patients diagnosed with the following illnesses are afforded legal protection under this act: *Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, nail patella*, or the treatment of these conditions. Patients are also offered legal protection if they have *a chronic or debilitating disease or medical condition or treatment of said condition that produces 1 or more of the following: cachexia or wasting syndrome; severe and chronic pain; severe nausea; seizures, including but not limited to those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis.* Patients (or their primary caregivers) may possess no more than 12 marijuana plants kept in an enclosed, locked facility or 2.5 ounces of usable marihuana. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. The state officially began accepting applications for the program on April 6, 2009.

RECIPROCITY: Yes. Authorizes visiting qualifying patient with registry identification card (or its equivalent) from a State that also allows the medical use of marijuana by visiting qualifying patients, to engage in the medical use of marijuana. Also authorizes a person to assist with a visiting qualifying patient's medical use of marijuana. Mich. Comp. Law § 333.26424(j) (2008).

(other state, district, territory, commonwealth, or insular possession of the U.S. must offer reciprocity to have reciprocity in Michigan)

AMMENDMENTS: Yes

Administrative rules for the program took effect on April 4, 2009. A copy of the regulations is available here.

ADDITIONAL AMENDMENTS: Yes

Schedule "B"

State lawmakers passed several bills in late 2012 specific to amending the Michigan Medical Marihuana Act. Changes to the law include:

- Requiring that those who transport medical marijuana must do so in a manner whereby the cannabis is inaccessible to the driver. Transport of marijuana must be in the trunk of a vehicle, unless the vehicle has no trunk, and only then may it be in the vehicle, if inaccessible, such as in an enclosed case. Violation of this law is punishable by a maximum penalty of 93 days in jail and/or $500 fine.
- Making doctors perform a "complete assessment" (in-person evaluation) of a patient before authorizing a recommendation for medical marijuana.
- Changing the renewal period from every year to every two years. Proof of residency is now required before one may obtain a registration card.
- Requiring that outdoor cannabis plants must not be "visible to the unaided eye from an adjacent property when viewed by an individual at ground level or from a permanent structure" and must be "grown within a stationary structure that is enclosed on all sides, except the base, by chain-link fencing, wooden slats, or a similar material that prevents access by the general public and that is anchored, attached or affixed to the ground, located on land that is owned, leased, or rented" by the registered grower and restricted to that grower's access.
- State-qualified caregivers must not have been convicted of any felony within the last ten years, or any violent felony ever.

These amendments took effect on April 1, 2013.

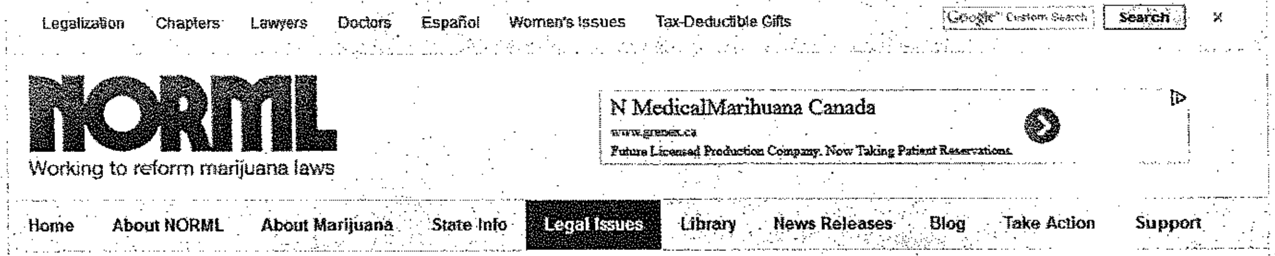
MEDICAL MARIJUANA STATUTES: Michigan Medical Marihuana Act, Mich. Comp. Law §§ 333.26421 - 333.26430 (2008).

CAREGIVERS: Yes. Primary caregiver is a person who has agreed to assist with a patient's medical use of marihuana. The caregiver must be 21 years of age or older. The caregiver can never have been convicted of a felony involving illegal drugs. Each patient can only have one primary caregiver. The primary caregiver may assist no more than 5 qualifying patients with their medical use of marihuana. Mich. Comp. Law §§ 333.26423; 333.26426(d) (2008).

CONTACT INFORMATION:

Michigan Medical Marihuana Program (MMMP)
Michigan.gov/mmp

Michigan Medical Marijuana Association
http://michiganmedicalmarijuana.org/



Montana Medical Marijuana

SUMMARY: Sixty-two percent of voters approved Initiative 148 on November 2, 2004. The law took effect that same day. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physicians authorizing the medical use of marijuana. Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia or wasting syndrome; severe or chronic pain; severe nausea; seizures, including but not limited to seizures caused by epilepsy; or severe or persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis or Crohn's disease.* Patients (or their primary caregivers) may possess no more than six marijuana plants. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients.

AMENDMENTS: Yes

Senate Bill 423, which became law on May 14, 2011, amends the state's medical marijuana law. The act went into effect on July 1, 2011. Among the changes mandated by this act:

- Chronic pain patients will face more stringent requirements to qualify under the law, and in some cases may require a recommendation from two separate physicians;
- Patients found guilty of marijuana DUI will have their medical marijuana privileges revoked;
- Advising physicians will be reported to the Board of Medical Examiners if they recommend for more than 25 patients per year; Physician will be responsible for the costs of this investigation;
- Caregivers may accept no monetary compensation for providing cannabis to qualified patients.

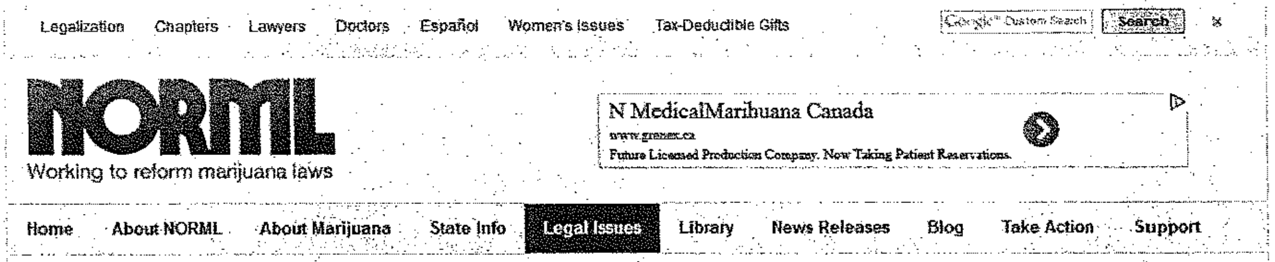
A comprehensive summary of the primary provisions of SB 423 may be found here. Full text of the measure is online here.

Several provisions of SB 423 are presently being litigated in court.

Schedule "B"

MEDICAL MARIJUANA STATUTES: Montana Medical Marijuana Act, Mont. Code Ann. §§ 50-46-1 to 50-46-2 (2007).

CONTACT INFORMATION: www.dphhs.mt.gov/medicalmarijuana/



Nevada Medical Marijuana

SUMMARY: Sixty-five percent of voters approved Question 9 on November 7, 2000, which amends the states' constitution to recognize the medical use of marijuana. The law took effect on October 1, 2001. The law removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who have "written documentation" from their physician that marijuana may alleviate his or her condition. Patients diagnosed with the following illnesses are afforded legal protection under this act: *AIDS; cancer; glaucoma*; and *any medical condition or treatment to a medical condition that produces cachexia, persistent muscle spasms or seizures, severe nausea or pain.* Other conditions are subject to approval by the health division of the state Department of Human Resources. Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than seven marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

The medical use provisions in Nevada do not include reciprocity provisions protecting visitors from other medical use states.

AMENDMENTS: Yes.

Governor Brian Sandoval signed legislation, SB 374, on June 12, 2013, authorizing the creation of up to 66 medical marijuana dispensaries. Under the law, state regulators are tasked with overseeing the creation of licensed establishments to produce, test, and dispense cannabis and cannabis-infused products to authorized patients.

Senate Bill 374 imposes limits on the home cultivation of cannabis if patients reside within 25-miles of an operating dispensary. However, patients who are cultivating specific strains of cannabis not provided by a local dispensary may continue to engage in the home cultivation of such strains. Patients who have an established history of cultivating medical cannabis prior to July 1, 2013, also may continue to do so until March 31, 2016. The bill also amends possession limits from one-ounce to two and one-half ounces and increases plant cultivation limits from three mature plants to twelve.

Medical marijuana products dispensed by state-licensed facilities will be subject to standard state sales taxes as well as a four percent excise tax, of which 75 percent will be directed to education and 25 percent will be directed toward implementing and enforcing the regulations.

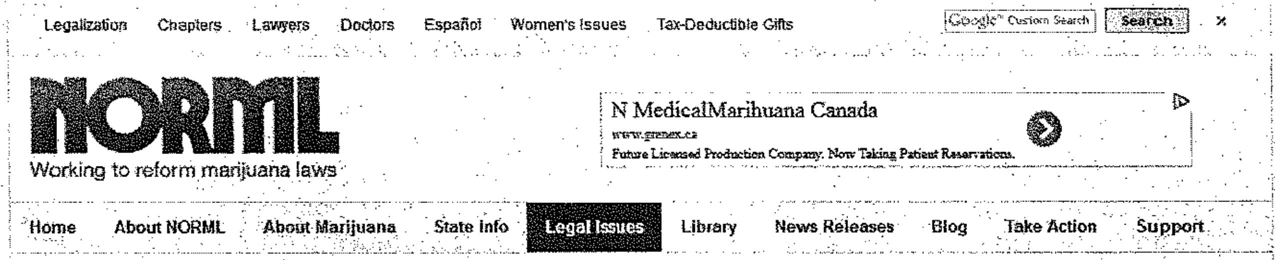
MEDICAL MARIJUANA STATUTES: Nev. Rev. Stat. §§ 453A.010 - 453A.240 (2008).

CAREGIVERS: Yes. Designated primary caregiver is a person who has significant responsibility for managing the well-being of a person diagnosed with a chronic or debilitating medical condition. Caregiver does not include the attending physician. The caregiver must be 18 years of age or older. Patients may only have one designated primary caregiver. Nev. Rev. Stat. Ann. §§435A.080(1)(a), (2); 435A.250(2) (2008).

CONTACT INFORMATION: Application information for the Nevada medical marijuana registry is available by writing or calling:

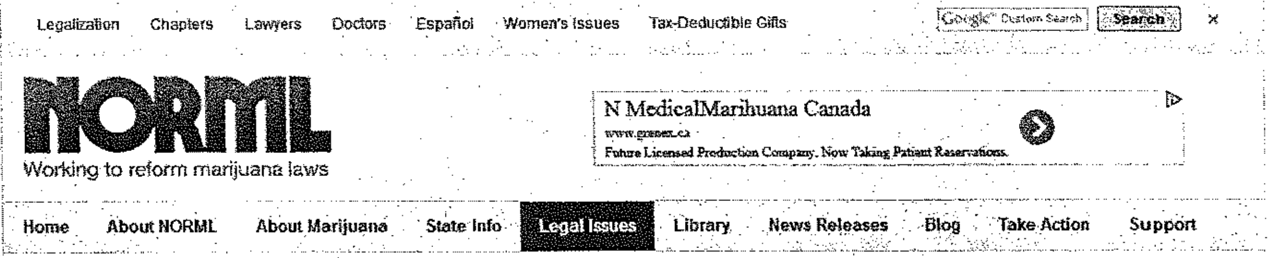
Nevada Department of Health and Human Services, Nevada State Health Division
4150 Technology Way, Suite 104
Carson City, Nevada 89706
Phone: 775-687-7594
Fax: 775-684-4156
health.nv.gov/MedicalMarijuana.htm

Schedule "B"



New Hampshire Medical Marijuana

SUMMARY: Democrat Gov. Maggie Hassan on July 23, 2013 signed legislation, House Bill 573, authorizing the physician-recommended use of cannabis for qualified patients. The law creates four state-sanctioned marijuana dispensing facilities to produce and distribute cannabis to state-qualified patients who possess a doctor's recommendation. Patients must have a preexisting relationship of at least three months with their physician prior to receiving a recommendation for cannabis therapy. Patients diagnosed with one of approximately twenty qualifying conditions -- including cancer, hepatitis C, muscular dystrophy, Crohn's disease, or multiple sclerosis -- are permitted to legally possess up to two-ounces of cannabis. Under the law, patients must obtain cannabis only from a state-licensed facility. Qualified patients will not be provided with any legal protections to possess or use cannabis prior to the establishment of such facilities. It has been estimated that it may take state regulators as much as two years to get the nascent program up and running.



New Jersey Medical Marijuana

SUMMARY: Governor Jon Corzine signed the New Jersey Compassionate Use Medical Marijuana Act into law on January 18, 2010. As initially passed, the law was scheduled to take effect in July 2010. However, lawmakers in June amended the legislation at the behest of Republican Gov. Chris Christie to delay the enactment of the law until October 1, 2010. The law mandates the state to promulgate rules governing the distribution of medical cannabis to state-authorized patients. These rules shall address the creation of up to six state-licensed "alternative treatment centers." Patients diagnosed with the following illnesses are afforded legal protection under this act: *cancer, glaucoma, seizure and/or spasticity disorders (including epilepsy), Lou Gehrig's disease, multiple sclerosis, muscular dystrophy, HIV/AIDS, inflammatory bowel disease (including Crohn's disease), any terminal illness if a doctor has determined the patient will die within a year.* Other conditions are subject to approval by the state Department of Health. Patients authorized to use marijuana under this act will not be permitted to cultivate their own cannabis, and are limited to the possession of two ounces of marijuana per month. Additional information on this measure is available here.

The medical use provisions in New Jersey do not include reciprocity provisions protecting visitors from other medical use states.

AMENDMENTS: Yes. Legislation (Senate Bill 2842), enacted in September 2013, amends state regulations to provide for the production and sale of multiple strains of cannabis and allows for the distribution of cannabis-infused edible products. Use of edible products will be limited to those age 18 or younger.

CAREGIVERS: Yes. Primary Caregiver is a person who has agreed to assist with a registered qualifying patient's medical use of marijuana. Primary caregiver cannot be the patient's physician. Primary caregiver must be a resident of New Jersey. The primary caregiver can never have been convicted of a felony drug offense. The caregiver must be 18 years of age or older. The caregiver may only have one qualifying patient at any one time. N.J. Stat. Ann. §24:6I-3 (2010).

- Primary caregivers must obtain a registry identification card from the Department of Health and Human Services. Applicants must agree to a criminal history

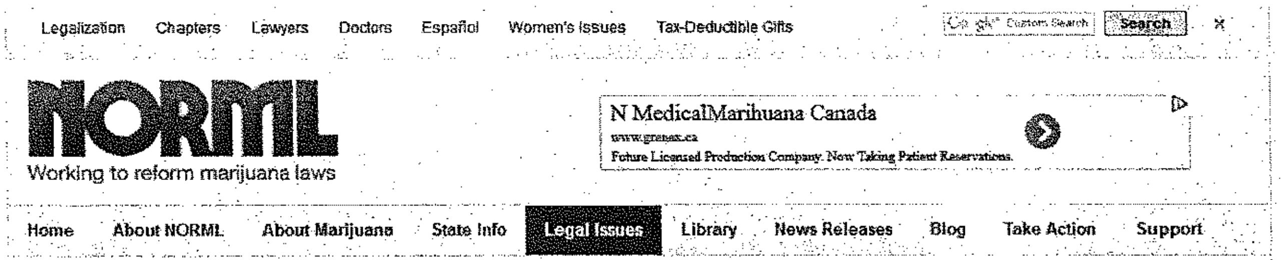
background check. The application fee is $200; registry identification cards are valid for 2 years.

FOR MORE INFORMATION:

Medical Marijuana Program -- Patient Registration Information
http://www.state.nj.us/health/medicalmarijuana/pat_reg.shtml

New Jersey NORML
http://www.normlnj.org

Coalition for Medical Marijuana -- New Jersey
http://www.cmmnj.org/



New Mexico Medical Marijuana

SUMMARY: Governor Bill Richardson signed Senate Bill 523, "Lynn and Erin Compassionate Use Act," into law on April 2, 2007. The new law took effect on July 1, 2007. The law mandates the state Department of Health by October 1, 2007, to promulgate rules governing the use and distribution of medical cannabis to state-authorized patients. These rules shall address the creation of state-licensed "cannabis production facilities," the development of a confidential patient registry and a state-authorized marijuana distribution system, and "define the amount of cannabis that is necessary to constitute an adequate supply" for qualified patients.

The medical use provisions in New Mexico do not include reciprocity provisions protecting visitors from other medical use states.

AMENDMENTS: Yes. In January 2009, the New Mexico Department of Health finalized rules governing the production, distribution, and use of medicinal cannabis under state law. Patients registered with the state Department of Health and who are diagnosed with the following illnesses are afforded legal protection under these rules:

- Arthritis
- Severe chronic pain
- Painful peripheral neuropathy
- Intractable nausea/vomiting
- Severe anorexia/cachexia
- Hepatitis C infection currently receiving antiviral treatment
- Crohn's disease
- Post-traumatic Stress Disorder
- Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)
- Cancer
- Glaucoma
- Multiple sclerosis
- Damage to the nervous tissue of the spinal cord with intractable spasticity
- Epilepsy
- HIV/AIDS
- Hospice patients

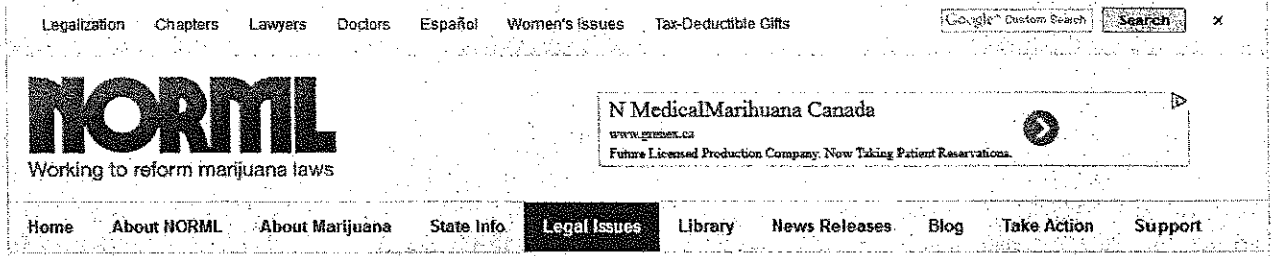
Other conditions are subject to approval by the Department of Health. Patients may legally possess six ounces of medical cannabis (or more if authorized by their physician) and/or 16 plants (four mature, 12 immature) under this act.

State regulations also authorize non-profit facilities to apply with the state to produce and dispense medical cannabis. State licensed producers may grow up to 95 mature plants at one time. **(UPDATE! The New Mexico Department of Health finalized revised regulations in December 2010 increasing *the number of plants that may be produced at one time from 95 to 150*. The updated regulations also allow licensed producers to obtain plants, seeds, and/or usable cannabis from other non-profit producers. The licensing fee for producers is: $5,000 for producers licensed less than one year, $10,000 for more than one year, $20,000 for more than two years and $30,000 for more than three years. For further information, please see: http://nmhealth.org/idb/medical_cannabis.shtml)**

MEDICAL MARIJUANA STATUTES: Lynn and Erin Compassionate Use Act, N.M. Stat. Ann. § 30-31C-1 (2007).

CAREGIVERS: Yes. Primary caregiver is designated by patient's practitioner as necessary to take responsibility for managing the well-being of a qualified patient with respect to the medical use of cannabis. Primary caregiver must be a resident of New Mexico. The caregiver must be 18 years of age or older. N.M. Stat. Ann. §26-2B-3(F) (2007).

CONTACT INFORMATION: Please contact the Medical Cannabis Program Coordinator at (505) 827-2321 or medical.cannabis@state.nm.us or visit www.nmhealth.org/marijuanahtml for more information.



Oregon Medical Marijuana

SUMMARY: Fifty-five percent of voters approved Measure 67 on November 3, 1998. The law took effect on December 3, 1998. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed recommendation from their physician stating that marijuana "may mitigate" his or her debilitating symptoms. Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*, *chronic pain*; *epilepsy and other disorders characterized by seizures; glaucoma*; *HIV or AIDS*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea*. Other conditions are subject to approval by the Health Division of the Oregon Department of Human Resources. Patients (or their primary caregivers) may legally possess no more than three ounces of usable marijuana, and may cultivate no more than seven marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

The Oregon law does not include a reciprocity provision. However, the Oregon Court of Appeals has ruled (and the Oregon Medical Marijuana Program has confirmed) that patients from out of state are permitted to register with the Oregon Medical Marijuana Program to obtain a registry identification card, the same as an Oregon resident, which will protect them from arrest or prosecution while in Oregon. These out of state patients are required to obtain a recommendation for the medical use of marijuana from an Oregon licensed physician. *State v. Berringer,* 229 P3d 615 (2010).

AMENDMENTS: Yes.

House Bill 3052, which took effect on July 21, 1999, mandates that patients (or their caregivers) may only cultivate marijuana in one location, and requires that patients must be diagnosed by their physicians at least 12 months prior to an arrest in order to present an "affirmative defense." This bill also states that law enforcement officials who seize marijuana from a patient pending trial do not have to keep those plants alive. Last year the Oregon Board of Health approved agitation due to *Alzheimer's disease* to the list of debilitating conditions qualifying for legal protection.

In August 2001, program administrators filed established temporary procedures further defining the relationship between physicians and patients. The new rule defines attending physician as "a physician who has established a physician/patient relationship with the patient; ... is primarily responsible for the care and treatment of the patients; ... has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file."

Also, Senate Bill 1085, which took effect on January 1, 2006, raises the quantity of cannabis that authorized patients may possess from seven plants (with no more than three mature) and three ounces of cannabis to six mature cannabis plants, 18 immature seedlings, and 24 ounces of usable cannabis. However, those state-qualified patients who possess cannabis in amounts exceeding the new state guidelines will no longer retain the ability to argue an "affirmative defense" of medical necessity at trial. Patients who fail to register with the state, but who possess medical cannabis in amounts compliant with state law, still retain the ability to raise an "affirmative defense" at trial.

Other amendments to Oregon's medical marijuana law redefine "mature plants" to include only those cannabis plants that are more than 12 inches in height and diameter, and establish a state-registry for those authorized to produce medical cannabis to qualified patients.

On June 6, 2013, the Governor signed Senate Bill 281 into law to expand the program's list of qualifying conditions to include post-traumatic stress.

MEDICAL MARIJUANA STATUTES: Oregon Medical Marijuana Act, Or. Rev. Stat. § 475.300 (2007).

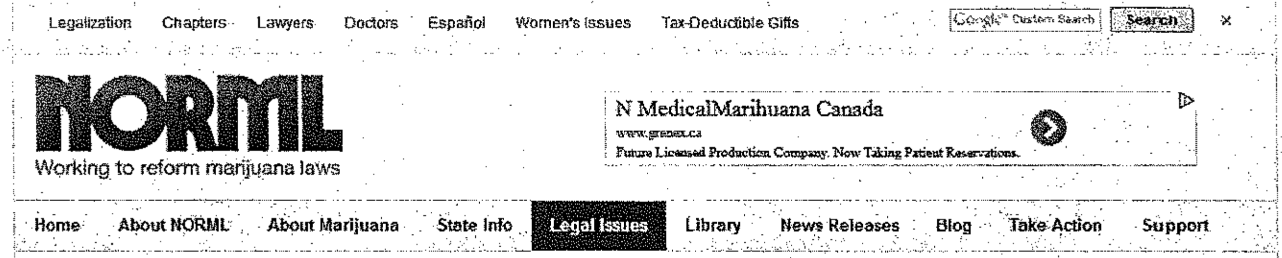
CAREGIVERS: Yes. Designated primary caregiver is the person that has significant responsibility for managing the well-being of a person who has been diagnosed with a debilitating medical condition. Primary caregiver does not include the patient's physician. The caregiver must be 18 years of age or older. A patient may only have one primary caregiver. Or. Rev. Stat. §§ 475.302(5); 475.312(2) (2007).

CONTACT INFORMATION: Application information for the Oregon medical marijuana registry is available online or by writing:

Oregon Department of Human Services
800 NE Oregon St.
Portland, OR 97232
(503) 731-4000
http://egov.oregon.gov/DHS/ph/ommp/index.shtml

Oregon Cannabis Patients registry: 1 (877) 600-6767

Oregon NORML Medical Marijuana Act Handbook (PDF)



Rhode Island Medical Marijuana

SUMMARY: The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act took effect immediately upon passage on January 3, 2006. The law removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess "written certification" from their physician stating, "In the practitioner's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient." Patients diagnosed with the following illnesses are afforded legal protection under this act: cachexia; cancer; glaucoma; Hepatitis C; severe, debilitating, chronic pain; severe nausea; seizures, including but not limited to, those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's Disease; or agitation of Alzheimer's Disease. Other conditions are subject to approval by the Rhode Island Department of Health. Patients (and/or their primary caregivers) may legally possess 2.5 ounces of cannabis and/or 12 plants, and their cannabis must be stored in an indoor facility. The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not register with the Department of Health, but have received certification from their physician to use medicinal cannabis, may raise an affirmative defense at trial.

RECIPROCITY: Yes. Authorizes a patient with a debilitating medical condition, with a registry identification card (or its equivalent), to engage in the medical use of marijuana. Also authorizes a person to assist with the medical use of marijuana by a patient with a debilitating medical condition. R.I. Gen. Laws § 21-28.6-4(k) (2006).

AMENDMENTS: Yes.

In June 2007, the Rhode Island House and Senate enacted legislation eliminating the sunset clause of the The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act, making the provisional program permanent

ADDITIONAL AMENDMENTS: Yes.

In 2009, lawmakers enacted legislation authorizing the establishment of state-licensed not-for-profit 'compassion centers' 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." The Rhode Island Department of Health will oversee the licensing and regulating of these facilities. Copies of the regulations are available for public inspection in the Cannon Building, Room #201, Rhode Island Department of Health, 3 Capitol Hill, Providence, Rhode Island, on the Department's website: http://www.health.ri.gov/ or the Secretary of State's website: http://www.sos.ri.gov/rules/, by calling 401-222-7767 or by e-mail to Bill.Dundulis@health.ri.gov.

However, in October 2011, Gov. Lincoln Chafee announced that he was suspending the licensing system indefinitely, stating: "I have decided that the State of Rhode Island cannot proceed with the licensing and regulation of medical marijuana compassion centers under current law. ... I have received communications from both the United States Department of Justice and from the United States Attorney for the District of Rhode Island that large scale commercial operations such as Rhode Island's compassion centers will be potential targets of 'vigorous' criminal and civil enforcement efforts by the federal government. I cannot implement a state marijuana cultivation and distribution system which is illegal under federal law and which will become a target of federal law enforcement efforts. I am hopeful that the General Assembly will introduce new legislation in the upcoming session that will address the flaws in, and indeed make improvement to, the existing medical marijuana card and caregiver system while not triggering federal enforcement actions."

ADDITIONAL AMENDMENTS: Yes.

In 2010, lawmakers enacted legislation, House Bill 8172, ensuring the confidentiality of medical marijuana patients' records. The law states, in part, "Applications and supporting information submitted by qualifying patients, including information regarding their primary caregivers and practitioners, are confidential and protected under the federal Health Insurance Portability and Accountability Act of 1996, and shall be exempt from the provisions of the RIGL chapter 38-2 et seq. the Rhode Island access to public records act and not subject to disclosure, except to authorized employees of the department as necessary to perform official duties of the department."

ADDITIONAL AMENDMENTS: Yes.

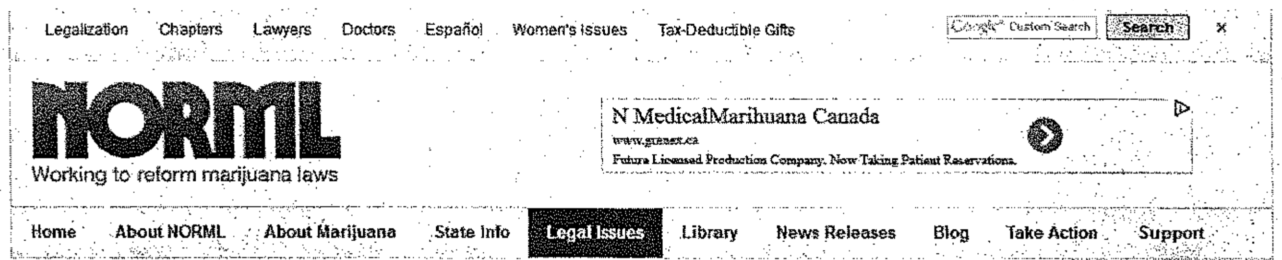
On Tuesday, May 22, 2012, Gov. Lincoln Chafee signed legislation, SB 2555, into law authorizing state regulators to license three small-scale 'compassion centers.' Under the law, compassion centers will not be allowed to cultivate more than 150 cannabis plants on the premises at any one time, only 99 of which may be mature. Centers will also be restricted to possessing no more than 1,500 ounces of usable product at any one time. Gov. Chafee had previously halted the implementation of a similar program, fearing that it would allow for the establishment of large-scale operations that would be targeted by federal law enforcement officials.

MEDICAL MARIJUANA STATUTES: The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act, R.I. Gen. Laws § 21-28.6 (2006).

CAREGIVERS: Yes. The caregiver must be 21 years of age or older. Primary caregiver may assist no more than 5 qualifying patients with their medical use of marijuana. R.I. Gen. Laws 1956, §21-28.6-3 (9) (2006).

CONTACT INFORMATION: http://www.health.state.ri.us/
Application Forms are available at www.health.ri.gov/hsr/mmp/index.php or by visiting room 104 at the Health Department, 3 Capitol Hill, Providence.

More helpful information can be found here: http://ripatients.org/.



Vermont Medical Marijuana

SUMMARY: Senate Bill 76 became law without Gov. James Douglas' signature on May 26, 2004. The law takes effect on July 1, 2004. The law removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients diagnosed with a "debilitating medical condition." Patients diagnosed with the following illnesses are afforded legal protection under this act: HIV or AIDS, cancer, and Multiple Sclerosis. Patients (or their primary caregiver) may legally possess no more than two ounces of usable marijuana, and may cultivate no more than three marijuana plants, of which no more than one may be mature. The law establishes a mandatory, confidential state-run registry that issues identification cards to qualifying patients.

The medical use provisions in Vermont do not include reciprocity provisions protecting visitors from other medical use states.

AMENDMENTS: Yes.

Senate Bill 7, which took effect on July 1, 2007, expands the definition of "debilitating medical condition" to include: "(A) cancer, multiple sclerosis, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, or the treatment of these conditions, if the disease or the treatment results in severe, persistent, and intractable symptoms; or (B) a disease, medical condition, or its treatment that is chronic, debilitating, and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome; severe pain; severe nausea; or seizures."

The measure also raises the quantity of medical cannabis patients may legally possess under state law from one mature and/or two immature plants to two mature and/or seven immature plants. Senate Bill 7 also amends state law so that licensed physicians in neighboring states can legally recommend cannabis to Vermont patients.

ADDITIONAL AMENDMENTS: Yes.

Senate Bill 17, which was signed into law on June 2, 2011, allows up to four state-licensed facilities to dispense marijuana to medically authorized patients. Each

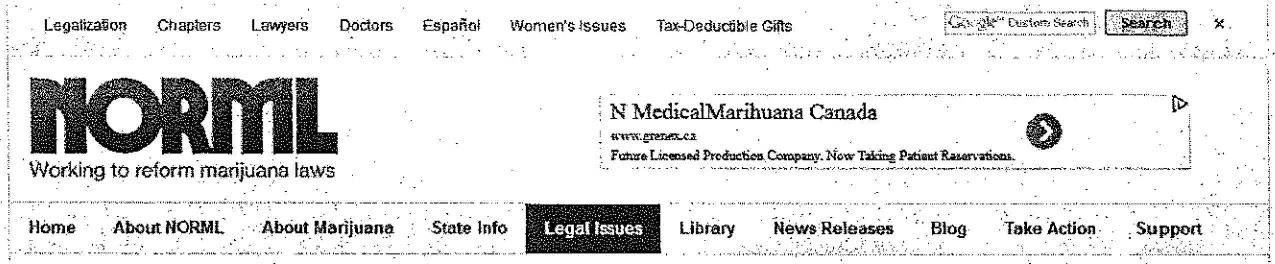
dispensary will be licensed by the state Department of Public Safety and will be permitted to serve up to 1,000 registered patients. The Department is in the process of developing rules to carry out the new law. The Department is anticipated to begin issuing licenses within six or seven months and must begin doing so within one year.

MEDICAL MARIJUANA STATUTES: Therapeutic Use of Cannabis, Vt. Stat. Ann. tit. 18, §§ 4471- 4474d (2003).

CAREGIVERS: Yes. Registered caregiver is a person who has agreed to undertake responsibility for managing the well-being of a registered patient with respect to the use of marijuana for symptom relief. The registered caregiver can never have been convicted of a drug-related crime. The caregiver must be 21 years of age or older. Patients may only have one registered caregiver at a time. Registered caregiver may serve only one registered patient at a time. Vt. Stat. Ann. Tit. 18, §4472(6); 4474(1),(2)(c) (2003).

CONTACT INFORMATION:

Marijuana Registry
Department of Public Safety
03 South Main Street
Waterbury, Vermont 05671
802-241-5115
www.safeaccessnow.org/article.php?id=2012



Washington Medical Marijuana

SUMMARY: Fifty-nine percent of voters approved Measure 692 on November 3, 1998. The law took effect on that day. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess "valid documentation" from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of the medical use of marijuana would likely outweigh the health risks." Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*, *HIV or AIDS*; *epilepsy*; *glaucoma*; *intractable pain* (defined as pain unrelieved by standard treatment or medications); and *multiple sclerosis*. Other conditions are subject to approval by the Washington Board of Health. Patients (or their primary caregivers) may legally possess or cultivate no more than a 60-day supply of marijuana. The law does not establish a state-run patient registry.

The medical use provisions in Washington do not include reciprocity provisions protecting visitors from other medical use states.

AMENDMENTS: Yes.

Senate Bill 6032, mandated the Department of Health to "adopt rules defining the quantity of marijuana that could reasonably be presumed to be a sixty-day supply for qualifying patients." In October 2008, the department finalized guidelines allowing patients to cultivate up to 15 cannabis plants and/or possess up to 24 ounces of usable marijuana. The new limits took effect on November 2, 2008.

Patients who possess larger quantities of cannabis than those approved by the Department will continue to receive legal protection under the law if they present evidence indicating that they require such amounts to adequately treat their qualifying medical condition.

Senate Bill 6032 also affirmed changes previously recommended by the state's Medical Quality Assurance Commission to expand the state's list of qualifying conditions to include Crohn's disease, hepatitis c, and any "diseases, including anorexia, which results in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, and/or spasticity, when these symptoms are unrelieved by standard treatments or medications."

It also limits the ability of police to seize medicinal cannabis that is "determined ... [to be] possessed lawfully [by an authorized patients] under the ... law."

ADDITIONAL AMMENDMENTS: Yes.

Senate Bill 5798 allows additional health care professionals including naturopaths, physician's assistants, osteopathic physicians, osteopathic physicians assistants, and advanced registered nurse practitioners to legally recommend marijuana therapy to their patients. The new law will take effect on June 10, 2010.

MEDICAL MARIJUANA STATUTES: Wash. Rev. Code §§ 69.51A - 69.51A.901 (2007).

CAREGIVERS: Yes. Designated provider is a person who has been designated in writing by a patient to serve as a designated provider. The caregiver must be 18 years of age or older. The designated provider is prohibited from consuming marijuana obtained for the personal, medical use of the patient for whom the individual is acting as designated provider. The designated provider may be the primary caregiver for only one patient at any one time. Wash. Rev. Code §§69.51A.010, 69.51A.040 (2007).

CONTACT INFORMATION: Fact sheets outlining Washington's medical marijuana law are available from:

Washington State Department of Health
101 Israel Road SE
Tumwater, WA 98501
(800) 525-0127
Attention: Glenda Moore
http://www.doh.wa.gov/

ACLU of Washington, Drug Reform Project
(206) 624-2184
http://www.aclu-wa.org/detail.cfm?id=182

No. T-2030-13

FEDERAL COURT

BETWEEN:

NEIL ALLARD
TANYA BEEMISH
DAVID HEBERT
SHAWN DAVEY

PLAINTIFFS

AND:

HER MAJESTY THE QUEEN IN RIGHT OF CANADA

DEFENDANTS

CERTIFICATE CONCERNING CODE OF CONDUCT FOR EXPERT WITNESSES

I, Paul Armentano, having been named as an expert witness by the Plaintiffs, certify that I have read the Code of Conduct for Expert Witnesses set out in the schedule to the Federal Courts Rules before the commissioning of my Affidavit and agree to be bound by it.

Dated: December 16, 2014

Paul Armentano
Expert Witness
NORML
1100 H Street, NW
Suite 830
Washington, DC 20005

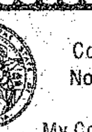
ATE OF CALIFORNIA
County Of Solano
Dec 16 2014, before me, Graciela Curiel, Notary public
(Here insert name and title of the officer)
ersonally appeared Paul Armentano
o proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) e subscribed to the within instrument and acknowledged to me that he/she/they executed same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed instrument.

certify under PENALTY OF PERJURY under the laws of the State of California that the oregoing paragraph is true and correct.

TNESS my hand and official seal.

ature of Notary Public (Notary Seal)

This is Exhibit "B" referred to in the affidavit of Paul Armentano



GRACIELA CURIEL
Commission # 2030231
Notary Public - California
Solano County
My Comm. Expires Jun 22, 2017