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

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TABLE OF CONTENTS

In 1996, California voters approved an initiative that exempted certain patients and their primary caregivers from state laws that criminalize the possession and cultivation of marijuana. In 2003, the Legislature enacted additional legislation relating to medical marijuana. One of those statutes directed the Attorney General to adopt "guidelines to ensure the security and nondiversion of marijuana grown for medical use." (Health & Safety Code, § 11362.81(d).[1]) The guidelines that follow are designed to (1) ensure that marijuana grown for medical purposes remains secure and does not find its way to non-patients or illicit markets, (2) help law enforcement agencies perform their duties effectively and in accordance with California law, (3) help patients and primary caregivers understand how they may lawfully cultivate, transport, possess, and use marijuana, and (4) provide guidance to state and local lawmakers regarding issues that may appropriately be addressed through statutes, ordinances, regulations, and rules.

I. SUMMARY OF APPLICABLE LAW

A. California Penal Provisions Relating to Marijuana.

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

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

On November 5, 1996, California voters passed Proposition 215, which decriminalized the cultivation and possession of marijuana by seriously ill individuals and their primary caregivers upon a physician's verbal or written recommendation. (§ 11362.5(d).) Proposition 215 was enacted to "ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana," and to "ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction." (§ 11362.5(b)(1)(A)-(B).)

Courts have found an implied defense under Proposition 215 to the transportation of medical marijuana when the "quantity transported and the method, timing and distance of the transportation are reasonably related to the patient's current medical needs." (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1551.) There is, however, no "unfettered right" for qualified patients or caregivers "to take their marijuana with them wherever they go, regardless of their current medical needs." (*People v. Wayman* (2010) 189 Cal.App.4th 215, 223.)

[1] Unless otherwise noted, all statutory references are to California's Health and Safety Code.

Proposition 215 does not grant immunity from arrest; it merely provides an affirmative defense to charges of unlawful cultivation or possession of marijuana. (See generally *People v. Mower* (2002) 28 Cal.4th 457, 474.) And finally, because Proposition 215 was adopted as an initiative statute, article II, section 10, subdivision (c) of the California Constitution prohibits the Legislature (or local governments) from amending its terms, or changing its scope and effect, without voter approval.

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

On January 1, 2004, Senate Bill 420, the Medical Marijuana Program Act (MMPA), became law. (§§ 11362.7-11362.83.) The MMPA, among other things, requires the California Department of Public Health (DPH) to maintain a program for the voluntary registration of qualified medical marijuana patients and their primary caregivers through a statewide identification card system. State medical marijuana identification cards are intended to help law enforcement officers identify and verify that cardholders are able to cultivate, possess, and transport certain amounts of marijuana without being subject to arrest under specified conditions. (§§ 11362.71(e), 11362.78.) The MMPA also fixes possession limits for cardholders, and recognizes a qualified exemption from criminal liability for the collective or cooperative cultivation of medical marijuana. (§§ 11362.7, 11362.77, 11362.775.)

It is mandatory that all counties participate in the identification card program by (a) providing applications upon request to individuals seeking to join the identification card program; (b) processing completed applications; (c) maintaining certain records; (d) following state implementation protocols; and (e) issuing DPH identification cards to approved applicants and designated primary caregivers. (§ 11362.71(b); *County of San Diego v. San Diego NORML* (2008) 165 Cal.App.4th 798, 825-828.)

Participation by patients and primary caregivers in the identification card program is voluntary. However, because identification cards offer the holder protection from arrest, are issued only after verification of the cardholder's status as a qualified patient or primary caregiver, and are immediately verifiable, they represent one of the best ways to ensure the security and non-diversion of medical marijuana. Information about the identification card program, as well as many useful links, may be found on DPH's website: www.cdph.ca.gov/programs/MMP/Pages/Medical Marijuana Program.aspx.

D. The Federal Controlled Substances Act.

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

The differences between federal and state law have given rise to understandable uncertainty, but no legal conflict exists merely because state law and federal law treat marijuana differently. Congress has provided that states are free to regulate in the area of controlled substances, including marijuana, provided that state law does not positively conflict with the CSA. (21 U.S.C. § 903.) Indeed, California's medical marijuana laws have been upheld against federal preemption challenges. (*County of San Diego*, *supra*, 165 Cal.App.4th at pp. 826-827; *Qualified Patients Ass'n v. City of Anaheim* (2010) 187 Cal.App.4th 734, 759-760, 763.) Neither Proposition 215, nor the MMPA, conflict with the CSA because, in adopting these laws, California did not attempt to legalize marijuana under federal law, but instead exercised the state's reserved powers to exempt certain marijuana offenses from punishment under state law when a physician has recommended its use to treat a serious medical condition. (See *City of Garden Grove v. Superior Court* (*Kha*) (2007) 157 Cal.App.4th 355, 371-373, 381-382.) The federal government has the power to adopt and enforce its own standards, but under the Tenth Amendment to the United States Constitution, it cannot force a state to implement a federal regulatory program.

In light of California's decision to remove certain individuals, groups, and activities from the sweep of the state's drug laws, this Office recommends that state and local law enforcement officers not arrest individuals or seize marijuana under federal law when the officer determines from the facts available that the cultivation, possession, or transportation is permitted under California's medical marijuana laws. This recommendation is not meant to change this Office's policy regarding the participation by state or local law enforcement agencies on joint state-federal drug task forces or operations.

E. Taxability of Medical Marijuana Transactions.

The California State Board of Equalization (BOE) has adopted a policy of taxing medical marijuana transactions and requiring that businesses engaging in such transactions hold a Seller's Permit. (www.boe.ca.gov/news/pdf/medseller2007.pdf.) According to BOE, the Seller's Permit does not allow individuals to make unlawful sales, it merely provides a way to remit any sales and use taxes due. BOE clarified its policy in a June 2007 Special Notice (www.boe.ca.gov/news/pdf/173.pdf), and again in a January 2010 Special Notice that focuses on payment of tax liabilities. (www.boe.ca.gov/news/pdf/l245.pdf.) In February 2011, BOE ruled that the sale of medical marijuana is not exempt from sales tax as exempt medicine. (www.boe.ca.gov/news/2011/32-11-H.pdf.)

F. Medical Standards Applicable to Physician Recommendations.

The Medical Board of California licenses, investigates, and disciplines physicians. (See Bus. & Prof. Code, §§ 2000-2521.) Although state law prohibits punishing physicians simply for recommending marijuana for treatment of a serious medical condition (§ 11362.5(c)), the Board can and does take disciplinary action against physicians who fail to adhere to accepted medical standards when evaluating patients and recommending marijuana, or who violate rules against the corporate practice of medicine.

The Medical Board has clarified that the standards that a physician must follow when recommending marijuana to a patient are the same ones that a reasonable and prudent physician would follow when recommending or approving any medication. According to the Board,[2] a medical marijuana consultation should involve:

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

Complaints about physicians may be lodged with the Medical Board by calling (800) 633-2322, or by visiting www.mbc.ca.gov/consumer/complaint_info.html.

II. DEFINITIONS

A. Physician's Recommendation: Physicians may not *prescribe* marijuana because the U.S. Food and Drug Administration regulates prescription drugs, and marijuana is not a prescription drug. Physicians may, however, lawfully issue a verbal or written *recommendation* under California law indicating that marijuana would be a beneficial treatment for a serious medical condition. (§ 11362.5(d); *Conant v. Walters* (9th Cir. 2002) 309 F.3d 629, 632.)

B. Primary Caregiver: A primary caregiver is a person who is designated by a qualified patient and "has consistently assumed responsibility for the housing, health, or safety" of the patient. (§ 11362.5(e).) The owner or operator of a licensed clinic, health care facility, residential care facility, or a hospice or home health agency also may be designated as a primary caregiver. (§ 11362.7(d)(1).)

A person does not become a primary caregiver merely by having a patient designate him or her as such. California courts have emphasized the need for a substantive patient-caregiver relationship. Although a "primary caregiver who consistently grows and supplies . . . medicinal marijuana for a section 11362.5 patient is serving a health need of the patient," someone who merely maintains a source of marijuana does not automatically become the party "who has consistently assumed responsibility for the housing, health, or safety" of that purchaser. (*People ex rel. Lungren v. Peron* (1997) 59 Cal.App.4th 1383, 1390, 1400.)

[2] See www.mbc.ca.gov/board/media/releases_2004_05-13_marijuana.html

To qualify as a primary caregiver, an individual must show that "he or she (1) consistently provided caregiving, (2) independent of any assistance in taking medical marijuana, (3) at or before the time he or she assumed responsibility for assisting with medical marijuana." (*People v. Mentch* (2008) 45 Cal.4th 274, 283.) In short, the person must show "a caretaking relationship directed at the core survival needs of a seriously ill patient, not just one single pharmaceutical need." (*Id.* at p. 286.)

A person may serve as primary caregiver to "more than one" patient if the patients and caregiver all reside in the same city or county, but may only serve as primary caregiver to one patient outside his or her own city or county of residence. (§ 11362.7(d)(2)-(3).)

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

D. Recommending Physician: A recommending physician is a person who (1) possesses a license in good standing to practice medicine in California; (2) has taken responsibility for some aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient; and (3) has complied with accepted medical standards that a reasonable and prudent physician would follow when recommending or approving marijuana for the treatment of his or her patient (see discussion in Section I.F, above).

III. GUIDELINES REGARDING INDIVIDUAL QUALIFIED PATIENTS AND PRIMARY CAREGIVERS

A. State Law Compliance Guidelines.

1. Physician Recommendation: To qualify for protection under Proposition 215 or the MMPA, patients must obtain a written or verbal recommendation for marijuana from a licensed physician. (§ 11362.5(d).)

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

3. **Proof of Qualified Patient Status:** Although verbal recommendations are technically permitted under Proposition 215, this Office strongly recommends that patients obtain and carry written proof of their physician recommendations to help them avoid arrest. A state identification card is the best form of proof, because it is easily verifiable and provides statutory immunity from arrest if certain conditions are met (see Section III.B.4, below.) Other identification or membership cards, such as those issued by collectives and cooperatives, should generally not be relied upon by qualified patients or law enforcement.

4. **Primary Caregiver Liability:** Under the MMPA, primary caregivers cannot be held criminally liable for certain acts, including the receipt of reasonable compensation for their services. Specifically, it provides that a "designated primary caregiver who transports, processes, administers, delivers, or gives away" certain amounts of marijuana to his or her patient is not subject, on that sole basis, to criminal liability for marijuana possession, transportation, cultivation, distribution, or sales. (§ 11362.765(a), (b).) It further provides that primary caregivers who receive "compensation for actual expenses, including reasonable compensation incurred for services provided to enable [a patient] to use marijuana," or "payment for out-of-pocket expenses incurred in providing those services," are not on that sole basis subject to criminal liability for marijuana distribution or sales. (§ 11362.765(c).)

5. **Possession Limits:**

   a. **MMPA Cardholders:** Unless a physician recommends a larger quantity, qualified patients and primary caregivers who obtain a state-issued identification card (see Sections I.C & III.A.2) may possess 8 oz. of dried marijuana, and may maintain no more than 6 mature or 12 immature plants per qualified patient, without being subject to arrest. (§§ 11362.71(e), 11362.77(a)-(b).) Only the dried mature processed flowers or buds of the female cannabis plant should be considered when determining allowable quantities of medical marijuana for purposes of the MMPA. (§ 11362.77(d).)

   b. **Local MMPA Possession Limits:** Counties and cities may adopt guidelines that allow qualified patients or primary caregivers with state identification cards to possess medical marijuana in amounts that exceed the MMPA's possession limits. (§ 11362.77(c).)

   c. **Proposition 215:** Qualified patients or primary caregivers claiming protection under Proposition 215 may possess and transport an amount of marijuana that is "reasonably related to [the patient's] current medical needs." (*Trippet*, *supra*, 56 Cal.App.4th at p. 1549.) The MMPA's possession limits do not apply to individuals asserting a defense under Proposition 215. (*People v. Kelly* (2010) 47 Cal.4th 1008, 1043.**)**

B. Use and Enforcement Guidelines:

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

2. **Use of Medical Marijuana in the Workplace or at Correctional Facilities:** The medicinal use of marijuana need not be accommodated in the workplace, during work hours, or at any jail, correctional facility, or other penal institution. (§ 11362.785(a).) Furthermore, an employer may terminate an employee who tests positive for medical marijuana without violating the Fair Employment and Housing Act or subjecting itself to a cause of action for termination in violation of public policy. (*Ross v. Raging Wire Telecomms., Inc.* (2008) 42 Cal.4th 920, 929, 933.)

3. **Criminal Defendants, Probationers, and Parolees:** Criminal defendants and probationers may request court approval to use medical marijuana while they are released on bail or probation. The court's decision and reasoning must be stated on the record and in the minutes of the court. (§ 11362.795(a)(1)-(2).) Likewise, parolees who are eligible to use medical marijuana may request that they be allowed to continue such use during the period of parole. The written conditions of parole must reflect whether the request was granted or denied. (§ 11362.795(b)(1)-(2); see also *People v. Brooks* (2010) 182 Cal.App.4th 1348, 1352-1353 [trial court could condition probation on non-possession of medical marijuana as condition was related to crime of possession of marijuana for sale]; *People v. Moret* (2010) 180 Cal.App.4th 836, 856-857 [court may condition probation on non-use of medical marijuana].)

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

    a. Review the identification card and verify its validity by accessing DPH's card verification website (www.calmmp.ca.gov); and

b. If the card is valid and not being used fraudulently, there are no other indicia of illegal activity (weapons, illicit drugs, or excessive amounts of cash), and the person is within the state or local possession limits, the individual must be released and the marijuana should not be seized. Under the MMPA, "no person or designated primary caregiver in possession of a valid state medical marijuana identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana." (§ 11362.71(e).) Furthermore, a "state or local law enforcement agency or officer shall not refuse to accept an identification card issued by [DPH] unless the state or local law enforcement agency or officer has reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently." (§ 11362.78.)

5. Non-Cardholders: When a person claims protection under Proposition 215 or the MMPA, but only has a written (or verbal) recommendation from a licensed physician, officers should use their sound professional judgment to assess the validity of the person's medical-use claim:

a. Officers need not abandon their search or investigation. Standard search and seizure rules apply to potential violations of medical marijuana laws. Reasonable suspicion is required for detention, while probable cause is required for search, seizure, and arrest.

b. Officers should review and, if possible, validate any written documentation. It may contain the recommending physician's name, telephone number, address, and license number.

c. If the officer reasonably believes that the medical-use claim is valid based upon the totality of the circumstances, and the person is within state or local possession limits or possesses an amount that appears to be consistent with their current medical needs, the person should be released and the marijuana should not be seized.

d. Alternatively, if the officer has probable cause to doubt the validity of a person's medical marijuana claim based upon the facts and circumstances (including the quantity of marijuana, packaging for sale, weapons, illicit drugs, pay-owe sheets, or large amounts of cash), the person may be arrested and the marijuana may be seized. It will then be up to the person to establish his or her medical marijuana defense in court if the district attorney elects to prosecute the case.

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

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

7. **Probable Cause:** Law enforcement officers must have probable cause before they lawfully may arrest a person for any crime. In the medical marijuana context, probable cause is required before searching or arresting an individual suspected of possessing, cultivating, or transporting marijuana for a purpose unrelated to the individual's personal medical needs. (See, e.g., *County of Butte v. Superior Court* (2009) 175 Cal.App.4th 729, 737-738 [state law enforcement officers may not order a qualified patient to destroy marijuana plants without probable cause to believe they are contraband].) A probable cause determination may be based upon an officer's experience in narcotics investigation and his or her knowledge of medical marijuana laws. (See *People v. Hochanadel* (2009) 176 Cal.App.4th 997, 1019; see also *People v. Dowl* (2010) 183 Cal.App.4th 702, 711 [a law enforcement officer is not required to qualify as a medical marijuana expert to testify that a qualified patient possessed marijuana for sale].)

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

IV. GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

The MMPA gives patients and caregivers a limited right to collectively and cooperatively cultivate marijuana. Section 11362.775 provides that:

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

The MMPA does not define the terms collective or cooperative, but it is the opinion of this Office that any group that is collectively or cooperatively cultivating and distributing medical marijuana to its members should be organized and operated in a manner that ensures the security of the crop and safeguards against diversion for non-medical purposes.

A. Dispensary:

The term "dispensary" is not found in Proposition 215 or defined in the MMPA, but it is commonly used in relation to the cultivation and distribution of medical marijuana. Dispensary generally refers to any individual or group that is dispensing or otherwise distributing medical marijuana grown by one or more of its members to the other members of the enterprise. The types of dispensaries currently operating in California include commercial businesses, such as those that dispense from storefronts, offices, agricultural lands, and through delivery services; and non-commercial individuals or groups that dispense from residences, agricultural land, and other physical locations. No matter the form of the enterprise, it should be organized as a collective or cooperative *and may not make a profit*.

B. Business Forms:

1. Statutory Cooperatives:

No business may call itself a "cooperative" (or "co-op") unless it is properly organized and registered as such under the Corporations or Food and Agricultural Code. (Corp. Code, § 12311(b).) A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. (*Id.*, §§ 12201, 12300.) Cooperative corporations are "democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons." (*Id.*, § 12201.) The earnings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (*Ibid.*) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from members each year. (See *id.*, § 12200, et seq.) Agricultural cooperatives are likewise nonprofit corporate entities "since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers." (Food & Agric. Code, § 54033.) Agricultural cooperatives share many characteristics with consumer cooperatives. (See, e.g., *id.*, § 54002, et seq.) Cooperatives should not acquire marijuana from, nor distribute it to, non-members.

2. Collectives:

As noted, the MMPA does not define collectives, but the dictionary defines them as "a business, farm, etc., jointly owned and operated by the members of a group." (*Random House Dictionary*; Random House, Inc. © 2010.) As such, a collective should not be owned by any one person or limited group of persons, only by the membership as a whole – a membership limited to qualified patients and primary caregivers. A collective also should not acquire marijuana from, nor distribute to, non-members; instead, it should be an organization that merely facilitates the collaborative efforts of patient and caregiver members – including the allocation of work, costs, and revenues. Even though a collective is not a statutory entity, as a practical matter it should organize as some form of business to carry out any commercial activities it may conduct.

C. Edible and Mislabeled Medical Marijuana Products:

Many medical marijuana collectives and cooperatives offer food products to their members that contain marijuana or marijuana derivatives. These edible cannabis products, which include cookies, brownies, butter, oil, fudge, lollipops, ice cream, and cupcakes, are not monitored and regulated like commercially distributed food products or pharmaceuticals. Furthermore, some dispensaries promote the efficacy of certain strains of marijuana to treat particular ailments, or fail to label marijuana or marijuana-based food products offered to members with manufacturing or source information, accurate weight, or instructions for proper dosage or use.

The manufacture, sale, labeling, advertising, and dispensing of food and drugs are extensively regulated in California under the Sherman Food, Drug, and Cosmetic Law, which is codified in sections 109875-111915 of the Health & Safety Code (the "Sherman Law"). The advertising, labeling, and delivery of marijuana via food products is not addressed in Proposition 215 or the MMPA, nor do these laws specifically exempt medical marijuana and related food products from the reach of the Sherman Law. Accordingly, state and local authorities have begun focusing on the safety, labeling, and advertising of medical marijuana, and the adulteration and distribution of food products with marijuana or THC, through the lens of the Sherman Law. Although California's appellate courts have yet to apply the Sherman Law in the medical marijuana context, cooperatives and collectives that manufacture or offer edible marijuana products to their members, sell it to dispensaries, cooperatives, or collectives, or offer loose, unlabeled marijuana for sale, do so at their own risk, and should ensure that they are complying with applicable state and local food and drug safety and labeling laws, as well as Proposition 215 and the MMPA.

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

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

1. Non-Profit Operation:

The MMPA confirms that for-profit sales are forbidden. (§ 11362.765(a) ["nor shall anything in this section authorize any individual or group to cultivate or distribute marijuana for profit"].) Thus, distribution and sales for profit of marijuana – medical or otherwise – remain criminal under California law. This Office is of the opinion that any monetary payment, or any provision of goods or services, in exchange for medical marijuana, be it a fixed membership fee or reimbursement for medical marijuana received, should be documented and be carefully calculated to provide no more in value than the actual cost of cultivating and providing medical marijuana to members and that there be no profit for any person in the supply chain from cultivator to patient. If a dispensary, cultivator, delivery service, or other collective or cooperative enterprise is profiting from its activities, its members may be subject to prosecution under California's marijuana laws. (See Section I.A, above.)

It also is the opinion of this Office that any compensation paid by a collective or cooperative to members who perform work for a dispensary (including marijuana cultivation), or who operate the dispensary, should not be excessive nor calculated to artificially diminish or hide profits. Generally, "reasonable compensation" is defined as reasonable wages and benefits paid to persons with similar job descriptions and duties, levels of education and experience, prior individual earnings histories, and number of hours worked. The payment of large bonuses should not be considered part of "reasonable compensation."

2. Sales and Reimbursement:

The MMPA provides that certain persons who "associate collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions" for a variety of otherwise prohibited conduct, including distribution and sales. (§ 11362.775.) The extent to which reimbursement by members to a collective or cooperative constitutes distribution or sales that are exempted from criminal liability by section 11362.775 is an unresolved legal question, and some local jurisdictions contend that all such transactions are criminal. Whether monetary transactions between a collective and its members are criminal or not, local jurisdictions may have the power to place limitations on them as an exercise of local zoning, permitting, and licensing authority. (See Section V, below.)

3. Location of Collectives and Cooperatives:

The MMPA provides, with certain exceptions, that "[n]o medical marijuana cooperative, collective, dispensary, operator, establishment, or provider who possesses, cultivates, or distributes medical marijuana . . . shall be located within a 600-foot radius of a school." (§ 11362.768.) As explained in Section V below, local jurisdictions may place additional restrictions on the location of collectives and cooperatives because the MMPA "does not confer on qualified patients and their caregivers the unfettered right to cultivate or dispense marijuana anywhere they choose." (*Hill v. County of Los Angeles* (2011) 192 Cal.App.4th 861 at p. *4.)

4. Business Licenses, Sales Tax, and Seller's Permits:

As explained in Section I.E of these Guidelines, those engaging in medical marijuana transactions must obtain a Seller's Permit and remit state sales tax. Some cities and counties also require dispensing collectives and cooperatives to obtain appropriate permits and business licenses.

5. Membership Application and Verification:

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

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

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

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

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

e. Track when members' medical marijuana recommendation and/or identification cards expire;

f. Have the individual identify any memberships in other collectives and state the necessity for such multiple memberships; and

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

6. Collectives and Cooperatives Should Possess and Distribute Only Lawfully Cultivated Marijuana:

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

7. Membership in Multiple Collectives and Cooperatives:

The MMPA provides certain individuals the right to act collectively or cooperatively to cultivate medical marijuana, but it does not specifically address whether individuals may be members of multiple collectives or cooperatives. Patients and primary caregivers who merely cultivate large quantities of marijuana and supply it to more than one collective or cooperative create security risks and increase the chance of diversion for non-medical purposes. Accordingly, this Office is of the opinion that collectives and cooperatives should not (1) permit members to have memberships in other collectives or cooperatives without identifying such memberships and stating the need for multiple memberships, nor (2) acquire medical marijuana or edible products from any member or entity that supplies marijuana to other collectives or cooperatives.

8. Collectives and Cooperatives Are Not Primary Caregivers:

A collective or cooperative that supplies marijuana to a qualified patient does not qualify as a primary caregiver on that basis alone. (See *People v. Mentch* (2008) 45 Cal.4th 274, 283-286.)

9. Distribution and Sales to Non-Members are Prohibited:

A collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization.

10. Permissible Reimbursements and Allocations:

Marijuana grown at a collective or cooperative for medical purposes may be:

a. Provided free to qualified patients and primary caregivers who are members of the collective or cooperative;

b. Provided in exchange for goods provided or services rendered to the entity;

c. Allocated based on fees that are directly calculated to cover actual costs, including overhead costs and operating expenses (see Sections IV.D.1-2); or

d. Any combination of the above.

11. Possession, Transportation, and Cultivation Limits:

If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits for each patient. For example, applying the MMPA's basic possession limits, if a primary caregiver with a state issued identification card is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow up to 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to

their membership numbers. To document the legitimacy of large quantities of marijuana, caregivers, collectives or cooperatives should have supporting records readily available when:

a. Operating a location for cultivation;

b. Transporting the group's marijuana; or

c. Operating a location for distribution to members of the collective or cooperative.

E. Criminal Enforcement Guidelines:

Depending upon the facts and circumstances, indicia that marijuana is not being grown, transported, or distributed for medical use may give rise to probable cause for search, seizure, and arrest. (See *People v. Hochanadel*, *supra*, 176 Cal.App.4th at pp. 1017-1018 [probable cause required to establish that a cooperative or collective is not operating within the law].) A law enforcement officer's experience in narcotics investigation, coupled with his or her knowledge of state medical marijuana laws, is sufficient to establish competence to author a search warrant affidavit. (*Id.* at p. 1019.) The following are additional guidelines to help identify medical marijuana collectives and cooperatives that are operating outside of state law.

1. Dispensaries:

As noted above, the only statutorily-recognized group cultivation entities are cooperatives and collectives. (§ 11362.775.) It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront, or through other means as identified in Sections IV.A and B above, may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines set forth above, are likely operating outside the protections of Proposition 215 and the MMPA, and that the individuals operating such entities may be subject to arrest and criminal prosecution under California law. (See, e.g., *People v. Hochanadel*, *supra*, 176 Cal.App.4th 997, 1018-1019 [dispensary operators were properly arrested where there was no evidence that purchasers were actual members of a cooperative or collective and some of the marijuana offered for sale was purchased from an outside source]; *Peron*, 59 Cal.App.4th at p. 1400 [dispensary owner was not the primary caregiver to thousands of patients].)

2. Indicia of Unlawful Operation:

When investigating collectives or cooperatives, law enforcement officers also should be alert for signs of mass production or illegal sales, including (a) financial records suggesting that a profit is being made, (b) excessive amounts of marijuana, (c) excessive amounts of cash, (d) failure to follow local and state laws applicable to similar businesses, such as maintenance of any required licenses and payment of any required taxes, including sales taxes, (e) weapons, (f) illicit drugs, (g) purchases from, or sales or distribution to, non-members, or (h) distribution outside of California.

V. GUIDELINES FOR LOCAL JURISDICTIONS IN REGULATING COOPERATIVES AND COLLECTIVES

California law provides two basic mechanisms for local jurisdictions to ensure that marijuana grown for medical purposes remains secure and does not find its way to non-patients or illicit markets: (1) criminal enforcement, and (2) the establishment and enforcement of zoning, land use, licensing, and related ordinances. It is this Office's opinion that criminal enforcement is justified when individuals are operating outside the protections of Proposition 215 and the MMPA (see, e.g., *People v. Hochanadel*, *supra*, 176 Cal.App.4th at pp. 1016-1019), and that local ordinances and code enforcement are an efficient means to regulate the cultivation and distribution of medical marijuana by collectives and cooperatives. The following are examples of non-criminal restrictions that local jurisdictions may want to consider in regulating collectives and cooperatives:

A. Prohibition:

As discussed below, cities and counties have broad authority under their zoning, licensing, and permitting powers to regulate, and in many instances prohibit, various activities and enterprises. Some cities and counties have even prohibited collectives and cooperatives, however it is an unresolved legal question whether local jurisdictions have the power to enact such prohibitions.[3]

B. Operating Requirements:

Cities and counties have broad powers to adopt and enforce ordinances and regulations pertaining to medical marijuana collectives and cooperatives. (*Hill v. County of Los Angeles*, *supra*, 192 Cal.App.4th at p. *3 [unlicensed dispensary found to be a nuisance; county zoning, permitting, and licensing restrictions upheld against state law preemption challenge]; *City of Claremont v. Kruse* (2009) 177 Cal.App.4th 1153, 1175-1176 [holding that neither Proposition 215 nor the MMPA prohibit cities from using their zoning and licensing powers to regulate dispensaries]; *City of Corona v. Naulls* (2008) 166 Cal.App.4th 418, 433 [failure to comply with the city's procedural requirements before operating a medical marijuana dispensary created a nuisance per se pursuant to the municipal code; court upheld issuance of preliminary injunction].)

The following are requirements that local jurisdictions may, depending on local circumstances and the nature of the enterprise, consider imposing as requirements for operation to ensure the security and non-diversion of marijuana for non-medical use. Although courts have evaluated and upheld some of the following restrictions, the extent to which such limitations are permissible under Proposition 215 or the MMPA, and other applicable laws, could raise unresolved legal questions and will depend upon the circumstances in which the restrictions are applied:

[3] The issue of whether the State's medical marijuana laws preempt local ordinances banning collectives and cooperatives was raised in *Qualified Patients Ass'n v. City of Anaheim*, *supra*, 187 Cal.App.4th 734, but the Court of Appeal found that the issue was not yet ready for review and returned the case to the superior court for further proceedings. (*Id.* at pp. 755-756.)

1. Provisions for adequate security, such as security guards, security procedures, security-monitoring equipment, alarm systems, and adequate exterior lighting;

2. Capping the number of collectives and cooperatives permitted to operate commercially;

3. Background checks and suitability determinations for employees;

4. Limiting or otherwise restricting on-site cash transactions;

5. Limiting the amount of cash kept on-site and precluding cash machines from being present;

6. Zoning restrictions;

7. Limitations designed to ensure non-profit operation, such as reasonable and allowable compensation paid to employees and reimbursements to members for goods and services provided to the collective or cooperative;

8. Prohibit members from having memberships in more than one collective or cooperative without identifying such memberships and stating a medical need for such multiple memberships;

9. Prohibit acquisition of marijuana from any member who supplies medical marijuana to any other collective or cooperative;

10. Requirements for provision of subsidized medical marijuana to income-eligible patients;

11. Precluding medical marijuana recommendations from being issued by the collective or cooperative, e.g., a staff physician or other physician located on the premises;

12. Prohibiting on-site sales of alcohol or tobacco;

13. Requiring permits and business licenses;

14. Restricting the hours of operations;

15. Maintaining a community-relations staff person, and providing that person's contact information to law enforcement and neighbors in the immediate vicinity of the operation, to notify if there are operational problems with the establishment;

16. Limitations regarding on-site cultivation, including those imposed on other agricultural operations;

17. Rights of access for officials of the jurisdiction to ensure compliance with state law and local requirements;

18. Laboratory testing of marijuana to ensure patient safety regarding pesticides, contaminates, and cannabinoid levels;

19. Preparation of audit reports verifying compliance with state and local laws;

20. Requiring maintenance and audit of records that establish compliance with state and local laws;

21. Restrictions on locations, such as distances from other collectives and cooperatives, substance-abuse centers, playgrounds, parks, schools, libraries, and certain community-gathering places;

22. Compliance with state and local safety and health codes;

23. Compliance with all local ordinances applicable to businesses distributing any restricted product such as prescription medications and alcohol; and

24. Compliance with all of the guidelines set forth in the Attorney General's Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Purposes.

C. Clinics and Care Facilities:

Under the MMPA, the definition of primary caregiver expressly includes the owner or operator, and up to three employees designated by the owner or operator, of certain clinics, health care facilities, residential care facilities, hospices, and home health agencies. (§ 11362.7(d)(1).) Because such operations are expressly legal under the MMPA, when crafting ordinances, local jurisdictions should avoid sweeping such facilities into the description of prohibited uses or operations.