Legal Implications of Medical Marijuana

David F. “Max” Beach

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Acknowledgements ...

- People
  - Jeffrey Hergenrather, M.D., Society of Cannabis Clinicians
  - Sarah Urfer, M.S., Laboratory Director, ChemaTox
  - Barry Logan, Ph.D., F-ABFT, NMS Labs

- Websites
  - National Institute on Drug Abuse (NIDA) [www.drugabuse.gov](http://www.drugabuse.gov)
  - Society of Cannabis Clinicians [www.cannabisclinicians.org](http://www.cannabisclinicians.org)
Articles


http://www.mbc.ca.gov/Licensees/Prescribing/Medical_Marijuana.aspx
Schedule 1 Controlled Substances

- Opioids & opium derivatives
  - Heroin, certain morphines
- Hallucinogenic/psychedelic substances
  - LSD, mescaline, peyote
    - Marijuana (cannabis)
- Depressants
  - Methaqualone
- Stimulants
  - Methamphetamine
- Cannabimimetic agents
  - Synthetics – bath salts, incense, potpourri
PRESCRIPTION BLANK - NATIONAL PROHIBITION ACT

Rx
Whiskey 36
Syr.-One tablespoonful when indicated.

1226 2226

October 24, 1923

For Michael Tapan
317 West Santa Paula St.
Santa Paula, Calif.

John C hacen

FOR USE OF DRUGGIST OR PHARMACIST ONLY

PERMIT NO. 91137

Aug 29, 1923

John M. Nank

CANCHELED

(STATE)
Santa Paula, Cal.

THIS PRESCRIPTION MUST NOT BE REFILLED

SEE REGULATIONS FOR PENALTIES IMPOSED
ORDER FORM FOR OPIUM, ETC.

6th... Cal.

G. C. NICKELS

REGISTRY NO. 4738

To be filed in the

City of

Date

1919

Please ship goods by

Seasonally

NAME OF SENDER

G. C. NICKELS

ADDRESS

123 Main St.

CITY

Santa Barbara

STATE

CA

SHIP TO

G. C. NICKELS

ADDRESS

123 Main St.

CITY

Santa Barbara

STATE

CA

ITEMS SHIPPED

25 Opium Tablets

25 Morphine Tablets

25 Morphine Patches

25 Opium Tablets

RECEIVED

12/14/19

SIGNED

G. C. NICKELS

PHYSICIANS

Dr. Smith

Dr. Jones

UNITED STATES INTERNAL REVENUE

[Stamp]
Marijuana cannot be “prescribed”

**Prescription (Rx)**

- “A prescription is an order for medication which is dispensed to or for an ultimate user.” U.S. Dept. of Justice, DEA, *Practitioner’s Manual: An Informational Outline of the Controlled Substances Act* (2006)

- A physician who *prescribes* marijuana or other Schedule I drugs may be stripped of his federal DEA license and be prosecuted.
Components of Marijuana (Cannabis)
Cannabis generally

- Cannabis: botanical name of genus of annual flowering plants in Cannabaceae family
- 483 *known* compounds in cannabis, including at least 100 cannabinoids
- Cannabinoids produce mental & physical effects
- Two main sub-species: *C. sativa* & *C. indica*
First isolated & synthesized in 1964
Principal *psychoactive* constituent resulting in euphoria
Between 1996-2008, concentration of THC in CA increased from 2.17% to 9.93%
Some recreational strains now claim **33% THC**
Has anti-nausea, anti-spasmodic, anti-oxidant and appetite stimulating effects
Cannabidiol (CBD)

- Generally not psychoactive
- Mitigates effects of THC
- Triggers endocannabinoid system receptors
- Anti-inflammatory, anti-spasmodic, anti-anxiety, anti-convulsant, pain relief, possibly anti-tumoral
Charlotte – 2011

- Born 10/18/2006
- Dravet Syndrome (severe myoclonic epilepsy of infancy)
- 300 grand mal seizures per week
- DNR, WC bound, on hospice, feeding tube, O2, seizures every 30 minutes
Charlotte’s Web strain of MM

- Developed in CO by the Stanley brothers
- Original name: “Hippie’s Disappointment”
- 17% CBD, 0.3% THC
- Sells in CO & CA for $.05 per milligram
- Stanleys have waiting list of 1200 families
- Anecdotally: successfully treats drug-resistant pediatric epilepsy in at least 70-80% of children
Charlotte - 2013

- Thriving
- 2-4 seizures per month, mostly in her sleep
- Walks, rides her bike, talks, feeds herself
- Uses olive oil solution of CW under her tongue or in her food
Endocannabinoid System (ES)

- Present in all mammals as receptors & endocannabinoids
- Affects emotional & cognitive processes including appetite, pain sensation, memory & mood (i.e., “Runner’s High”)
- Receptors located throughout the body
- Endocannabinoids identical to plant-based cannabinoids
- Endocannabinoid production declines with age: may lead to age-related diseases (ACVD, arthritis, osteoporosis, CA, Alzheimer’s, Parkinson’s)
Endocannabinoid System (ES)

*C. sativa* strains mediated by CB1 receptors
- Highest concentration of CB1 receptors in central nervous system & brain
- Uplifting, energetic

*C. indica* strains mediated by CB2 receptors
- Highest concentration of CB2 receptors in peripheral tissue
- Relaxing, sedating
Cannabis Consumption

- Flower (buds), kief (powder), hashish (concentrated resin cake)
- Hash oil (extract using solvents)
- Concentrates, infusions, salves & tinctures (extracts using water, Co2, high-proof spirits)
- Edibles (cookies, brownies, candy, oil, butter, lozenges, tonics, lemonade, etc.)
- Methods of consumption: oral, oromucosal, inhaled, topical
Not to be confused with ...
Dronabinol (MARINOL®, synthetic delta-9-THC)

- Schedule 3 prescription drug approved for use by FDA in 1985
- **99% THC with none of the other cannabinoids**
- Taken PO (capsules)
- Slow onset (1/2-1 hr; peaks @ 2-4 hrs)
- Effect lasts 4-6 hrs, 2x as long as smoked marijuana

- Low absorption rate (10-20%), varies from person to person
- Hard to control dosage
- Not tested in geriatric patients
- Treats nausea/vomiting caused by chemo, loss of appetite & weight loss in AIDS
Nabilone (CESAMET™, synthetic cannabinoid)

- Schedule 2 (high potential for abuse) prescription drug approved for use by FDA in 1985
- Taken orally in 5 day course concurrent with single cycle of chemotherapy
- Treats nausea/vomiting caused by chemotherapy
- Mental effects can last 3-5 days after last dose
Nabiximols (SATIVEX®, whole-plant extract)

- **1:1 equal ratio of THC to CBD**
- Quality controlled: each bottle contains the same concentration of active ingredients
- Peppermint-flavored mouth spray
- Not FDA-approved
- Currently in Phase III trials (Fast Track) for treatment of MS-related muscle spasticity & intractable CA pain
- Also being tested as monotherapy for solid tumor
LEGALIZED MEDICAL MARIJUANA
Medical Marijuana

- Approved & regulated in 23 states, DC & Guam
- 3 states have now approved both medical & recreational use (Colorado, Washington, Alaska)
- Est. 2,434,192 legal MM users in U.S.
Some Qualifying Conditions

- ALS
- Alzheimer's
- Anorexia
- Arthritis
- Cachexia
- Cancer
- Crohn's Disease
- Glaucoma
- Hepatitis C
- HIV-AIDS
- Migraines
- MS
- Muscle pain & spasms
- Nausea
- Parkinson’s
- PTSD
- Seizure disorders
- Terminal illness if prognosis <12 months
724.4 Radiculopathy, lumbosacral region;
300 Anxiety disorder, unspecified;
311 Depressive disorder, single episode, unspecified
Conant v. Walter 309 F.3d 629 (9th Cir. 2002)

- Physicians have constitutionally-protected right to discuss MM as a treatment option with their patients and make oral or written recommendation for MM. (Emphasis added.)
- “... government may not initiate an investigation of a physician solely on the basis of a recommendation of marijuana within a bona fide doctor-patient relationship”
- Investigation requires “substantial evidence of criminal conduct”
State-specific information
Florida

Compassionate Use of Medical-Grade Marijuana

- Contains no more than 0.5% THC and at least 15% CBD
- Medical use does not include smoking – vaping is not considered smoking
- Physician must use alternate treatments first
- Physician must register patient on Compassionate Use Registry
Written certification can only be made in the course of a **bona fide physician-patient relationship**

- Physician must conduct a clinical visit
- Complete & document full assessment of patient’s medical history and current medical condition
- Explain potential risks/benefits of marijuana use
- Have a role in the patient’s ongoing care & treatment
Physician Certification must specify that patient is in physician’s **continuing care** for condition

Physician must consider what **form of medical marijuana** patient should use

MM may not be smoked

**New felony** for doctors who issue certification with reasonable grounds to know person has no medical need or not using MM to treat qualifying medical condition
Decriminalized cultivation & use of cannabis by seriously ill patients with physician’s recommendation

Physician must conduct medical exam before recording in medical record assessment of whether patient has serious medical condition and medical use of marijuana is appropriate

Serious medical condition includes “any chronic or persistent medical symptom that substantially limits a person from conducting 1 or more major life activities”
Colorado

Amendment 20 (2000) Medical Use of Marijuana for Debilitating Medical Conditions

- 2009 – 2010: MM registrations jump from 10,000 to 100,000
- 2008 – 2009: Dispensaries go from 0 to 250; over 1000 by 2010
- 2012: Personal Use Amendment 64 passes
- As of August 2014: 115,000 current registry ID cards; mostly male, average age 42
- 800+ recommending physicians
For the period 1999-2010 – researchers found a 24.8% lower annual opioid overdose death rate in states with legalized MM compared to those states without legalized MM.

Does State Law Legalizing Medical Marijuana Put the State/Patient/Provider in Violation of Federal Drug Law?

YES
Gonzalez v. Raich, 545 U.S. 1 (2005)

- “California’s State law is preempted under the Supremacy Clause when and where it comes in conflict with the Controlled Substances Act.”

- DEA Spokesman Richard Meyer: “According to federal law, there is no such thing as medical marijuana. Marijuana is a dangerous drug that the United States Congress has classified as a Schedule One substance. A Schedule One substance doesn't have any accepted medical use in the United States and a high potential for abuse.”
Does State Law Legalizing Medical Marijuana Put the State/Patient/Provider in Violation of Federal Drug Law?

NO
“The federal government’s policy [of targeting physicians for recommending marijuana as medicine] deliberately undermines the state by incapacitating the mechanism the state has chosen for separating what is legal from what is illegal under state law.”

“Applied to our situation, this means that, much as the federal government may prefer that California keep medical marijuana illegal, it cannot force the state to do so.” Hon. Alex Kozinski, US Court of Appeals for the Ninth Circuit, in his 2002 concurring opinion

*Conant v. Walter 309 F.3d 629 (9th Cir. 2002)*
Guidance to US Attorneys Regarding Marijuana Enforcement

- Prevent distribution of marijuana to minors
- Prevent sales revenue from going to criminal enterprises, gangs & cartels
- Prevent diversion from legal to nonlegal states
- Prevent state-authorized activities as cover/pretext for trafficking of other illegal drugs or other illegal activity
Guidance to US Attorneys Regarding Marijuana Enforcement

- Prevent violence & use of firearms in the cultivation and distribution
- Prevent DUID and exacerbation of other adverse public health consequences
- Prevent cultivation on public lands & attendant safety and environmental dangers
- Prevent possession or use on federal property
STANDARD OF CARE FOR PHYSICIANS PRESCRIBING MEDICAL MARIJUANA
STANDARD OF CARE FOR PHYSICIANS RECOMMENDING MEDICAL MARIJUANA
“Simply acceding to patient demands for a treatment on the basis of popular advocacy, without comprehensive knowledge of an agent, does not adhere to the ethical standards of medical practice ... any recommended therapy requires proof of concept by sound scientific study that attests to both efficacy and safety.”

STANDARD OF CARE FOR PHYSICIANS

ACCEPTED STANDARDS OF MEDICAL RESPONSIBILITY

- History & appropriate prior exam of patient
- Development of treatment plan with objectives
- Provision of appropriate consent including discussion of side effects
- Periodic review of treatment’s efficacy
- Consultation, as necessary
- Proper record keeping supporting decision to recommend the use of marijuana for medical purposes

Statement of CA Medical Board May 7, 2004; amended Oct. 2014
INFORMED CONSENT?

Side effects

- Addictive to 9% of adult users (alcohol 15%, opioids 23%, nicotine 32%)
- Short & long term cognitive effects
- Psychiatric conditions (from anxiety & depression to psychosis, including schizophrenia)
- Obstructive lung disease (no FDA-approved medication is smoked)
- Lung cancer
- Motor vehicle accidents
- Reproductive risks
GENERAL RECOMMENDATIONS

- Subject to same standards applicable to other prescription medications & devices
- Shouldn’t be distributed until approved by FDA
- Reject responsibility for providing access to MM
- Reject smoking as means of delivery since inherently unsafe
- Reject ballot approval of medications

RECOMMENDATIONS FOR PHYSICIANS

- History and good faith examination of patient
- Development of treatment plan with objectives
- Informed consent, including discussion of risks, side effects, and potential benefits
- Periodic review of treatment’s efficacy
- Consultation, as necessary
- Proper record keeping supporting decision to recommend use. President’s Action Comm. on MM of the Am. Society of Addiction Medicine. “The Role of the Physician in ‘Medical’ Marijuana.” Sept. 2010
MM AND THE LTC PROVIDER
Holocaust survivor Moshe Rute, 81, relaxes after smoking MM in the Hadarim nursing home in Kibbutz Naan, Rehovot, Israel, April 27, 2014
The Coming Geriatric Generation

- Raucous rebels of the 60s become the new geriatric generation
- Many boomers came of age smoking marijuana
- Do residents of LTC facilities have the right to smoke MM?
- Can a resident be evicted for smoking MM?
- Are smoking safely concerns alleviated with vaporizers?
Representative State LTC Policies

- **Maine**: Permits nursing homes and inpatient hospice workers to act as registered MM caregivers for patients
- **Michigan, Oregon, Rhode Island**: include “agitation of Alzheimer’s” as qualifying condition for legal use of MM
- **Montana**: smoking not permitted in any health care facility but cannabis may be used in other forms
- **New Mexico**: allows MM use in SNFs
NEW MEXICO LTC OMBUDSMAN

- Lack of dosing directions has caused problems
- “If the marijuana is kept at the nurses’ station, it tends to disappear.”
- “Pills in nursing homes are in what they call vacuum packs: you have to pop a pill out one at a time. They don’t do that with marijuana. It’s an amount of marijuana in a small plastic bag, so there is no way to track if someone took one or two pinches.”  Rashidian, N. & Martin, A. (2010, Oct. 27). “Medical Marijuana Raises Tough Questions for Nursing Homes.” New York Times, The New Old Age.
CAHF has received some questions about whether residents can use medical marijuana in the skilled nursing facility. Below is an email response from CMS on the subject, which concludes that federal law prohibits a SNF from dispensing medical marijuana.
Sec. 1819(d)(4) of the Social Security Act (42 U.S.C. 1395i-e(d)(4)) provides that “[a] skilled nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations ...”

Marijuana is a Schedule I controlled substance under the CSA, 21 U.S.C. 801, 812. This classification renders the manufacture, distribution, or possession of marijuana a criminal offense, CSA sections 841(a)(1), 844(a). In Gonzales v. Raich et al., 545 U.S. 1 (2005), the Supreme Court held that application of CSA provisions criminalizing the manufacture, distribution, or possession of marijuana to intrastate growers and users for medical purposes ... did not violate the Commerce Clause, i.e., was constitutional. The court also observed that “[t]he Supremacy Clause unambiguously provides that if there is any conflict between federal and state law, federal law shall prevail.”
“Given this legal context, we conclude that federal law prohibits a SNF from dispensing medical marijuana. As the court held, ‘even if respondents are correct that marijuana does have accepted medical uses and thus should be redesignated as a lesser schedule drug, the CSA would still impose controls beyond what is required by California law.’ They went on to hold that ‘the dispensing of new drugs, even when doctors approve their use, must await federal approval.’” (Emphasis added.)
LTC facilities must include assessment of smoking areas & provision of emergency equipment in those areas.

Facility should document how residents are assessed as safe to smoke without supervision.

e-cigarettes/vapor pens are not considered smoking devices.

CMS Tobacco Smoking Policy S&C: 12-04-NH, Updated 11/10/11
MEDICAL MARIJUANA DOSE DETERMINATION

- Standard dosage – unknown
- Volatility between strains, growing conditions vary
- No quality control or grading standards in place
- Methods of delivery – smoking, food products, infusions, tinctures, oils
- New York - physician “will determine the appropriate dosage based on his or her medical judgment”
Sample LTC Medical Marijuana Policy (Washington)

- This community supports the right to use medical marijuana consistent with the provisions of Chapter 69.51A RCW, as approved and directed by his/her health care professional and under certain circumstances within this LTC setting.

- Staff involvement limited to confirming receipt of qualifying documentation, confirming health care professional’s recommendation, & ensuring no other clients impacted by other’s use of MM.

Developed by the Washington Health Care Association (undated)
Sample LTC Policy continued

- Staff will not under any circumstances:
  - Assist client in obtaining/using MM
  - Store MM for client, take or use client’s MM
  - Serve as client’s designated provider of MM

- Provider is responsible for:
  - Bring MM to client, remove from premises after consumption.

- All MM consumed by client must be in edible form only.
- No MM will be grown or stored on premises.
Sonoma County assisted living facility
— Residential facility with 15 beds
— Day Club
— All clients have dementia
— At least 10 residents use MM regularly
— MDs and licensed staff have noted significant decrease in behaviors as described by Cohen-Mansfield Agitation Inventory
— FDA-approval for study pending
On the Horizon ...
On the horizon ...

- Jeffrey Hergenrather, M.D., President of the Society of Cannabis Clinicians
- Presented 2013 CME at UCSF – “Cannabis in Primary Care: Issues for the Practicing Physician.”
Continuing Medical Education at UCSF

Hergenrather presents study of Crohn’s patients as a template for clinical research on Cannabis

By O’Shaughnessy’s News Service

“Cannabis in Primary Care” was the title of Dr. Jeffrey Hergenrather’s presentation at the 2013 annual meeting for MDs by UCSF, MMJ13001 and B. The session was “Issues for the Practicing Physician: IBD, patient screening and monitoring.”

IBD – Inflammatory Bowel Disease, which includes Crohn’s and Ulcerative Colitis— might seem relatively exotic to include in an introductory talk about cannabis medicine. Hergenrather focused on it because his own study of IBD patients provides a model by which the effects of the herb can be evaluated as a treatment for any given disorder. Cannabis medicine is an emerging field, and it provides an unprecedented opportunity for doctors to conduct meaningful research. An efficient introduction to the body’s cannabinoid signaling system had been provided by Mark Ware, M.D., of The University of Texas Southwestern Medical School. Hergenrather’s results strongly suggest that herbal cannabis is beneficial in the treatment of Inflammatory Bowel Disease. Symptoms were reduced by a third, pain reduced by half, vomiting was down, appetite up. Overall, Hergenrather said, “patients’ quality of life is improved significantly.”

Cannabis and IBD

Hergenrather addressed many issues likely to concern MDs who have been taught nothing about cannabis in medical school but want to know what’s really known about its safety and efficacy, and what kinds of interactions to expect when discussing cannabis use with patients. “You’re going to get asked a lot of questions about strains,” Hergenrather advised, but there is no question to the potologist. Salvia are said to provide a “head high.” Users report feeling more “energetic, focused, alert, creative.”

Hergenrather described strains that tend to promote relaxation and “couch lock.” Names with “Kush” or “Afghan” tend to be indica-dominant. Also those with colors in their names, purple, blue, orange, black, etc. “Haze” and “Dutch” tend to be sativas. There’s so much crossing and hybridization that there are generalizations fall apart,” Hergenrather acknowledged.

Introducing CBD

Hergenrather described cannabinoid-rich cannabis as “the real star of the show.” He explained that physician,

“Let the patient know when you want to see them back and what you expect of them. Ask for lab work and imaging reports. And for anybody youthful, I want to see their grade cards. In general, they do much better when they’re using cannabis.”

“Ask for lab work and imaging reports. And for anybody youthful, I want to see their grade cards. In general, they do much better when they’re using cannabis.”

“Be willing to testify. This has everything to do with proper record keeping. I would have documentation supporting the diagnosis that I’m treating in advance of seeing the patient for the first time.”

“I like to quantify the use of cannabis and method of administration at every visit. It changes over time. After patients use it in vapor or topical forms, they’re going to use a lot more cannabis.”

“We have to ask for a release of liability because patients are going to be out there driving. The release of liability spells out issues that the patient needs to sign and say ‘Okay, this is on me and not on you.’ Those forms are available at cannabismedicine.org.”

“The federal courts support the physician’s right to have this relationship with the patient, including making a recommendation. This is not a permit to use cannabis for your own personal medical needs. It’s important to make that clear to the patient. This is the extent of it: you can grow what you need for your own use.”

Precautions

Hergenrather described cannabis use as “habit forming but not addictive.”
On the horizon ... scientific studies

- Dr. Hergenrather’s 2005 study showed half of participants with Crohn’s Disease able to stop daily use of conventional meds with MM

- His results confirmed in Israeli double-blind, placebo-controlled trial which found cannabis can induce complete remission of Crohn’s Disease.


— “Compared to currently approved drugs prescribed for the treatment of Alzheimer's disease, THC is a considerably superior inhibitor of Aβ aggregation ... cannabinoid molecules may directly impact the progression of this debilitating disease.”
ADDITIONAL PLAYERS IN MEDICAL MARIJUANA

DISPENSARIES

LABS
MARIJUANA DISPENSARIES
TESTING LABS
LAB TESTING

- Potency
  - Contains no more than 0.5% THC & at least 15% CBD (Florida)

- Contaminants, pesticides

- Methods of testing (gas, liquid chromatography)
Dear Registrant:

This letter is being sent to every Drug Enforcement Administration (DEA) registered analytical laboratory. DEA has recently received questions from analytical laboratories regarding from whom they may receive samples of controlled substances to conduct analytical testing for potency and contaminants. The purpose of this letter is to reiterate existing federal regulations on this matter.

The Controlled Substances Act (CSA) and its implementing regulations established a closed system of distribution so that controlled substances are at all times under the legal authority of an entity registered by DEA, or specifically exempted from registration. 21 U.S.C. § 822(a)(2) and 21 C.F.R. § 1301.11(a). All DEA registrants are required to carry out their activities involving controlled substances in conformity with the CSA and its implementing regulations.

DEA regulations govern any movement of controlled substances between these registered entities, thus the closed system facilitates an accurate accountability of all controlled substances from manufacturing through dispensing to ultimate users. A DEA registered analytical laboratory is only authorized to receive controlled substances for analysis from another DEA registrant, or an entity that is specifically exempted from registration pursuant to 21 C.F.R. § 1301.23 or 21 C.F.R. § 1301.24. Therefore, analytical laboratories are not authorized to accept controlled substances from individuals that are not registered, or are not specifically exempt from registration, with the DEA.

Questions regarding this correspondence may be directed to DEA’s Liaison and Policy Section, Office of Diversion Control, at (202) 307-4654.

Sincerely,

[Signature]

Joseph T. Rannazzisi
Deputy Assistant Administrator/
Deputy Chief of Operations
Office of Diversion Control
Representative MM Cases
Colorado

- **Coombs v. Beyond Broadway**: Dist. Ct, Denver County, CO, Case No. 2014CV33129 – Chocolate samples given away at Pot Pavilion, advertised to have no cannabis ingredients, 7 plaintiffs with symptoms of “THC overdose”. Ongoing class action.

- **Colorado Div. of Registrations**: 11/17/10: Denver MD – fell below SOC when he recommended MM for 20 yr old female without conducting physical exam, taking medical hx (28 weeks pregnant), or counseling her on risks of MM use during pregnancy. License surrendered.
California

- **CA Medical Board 3/20/12**: Lake County MD – failure to perform appropriate exams prior to issuing MM recommendations for 3 patients, failure to coordinate care with other practitioners, failure to obtain medical records. 5 years probation with conditions.

- **CA Medical Board 9/1/14**: Santa Cruz County MD – saw 60-70 patients on Fridays, charged $150-$250/patient but diagnoses actually made by PA. Charges included gross negligence in care & treatment of patients, repeated acts of negligence, incompetence, creation of false medical records. 45 day suspension of license, 5 years probation.
COVERAGE QUESTIONS
Marijuana and Insurance Coverage

- Available coverage for physicians:
  - Professional liability

- Available coverage for producers/growers:
  - Product liability
  - Crop loss and theft (valuable crops, harvested products)

- Available coverage for dispensaries:
  - Theft (valuable crops, harvested products)
  - Workers compensation
  - Auto liability (home delivery)
<table>
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<tr>
<th>MAX BEACH – LEGAL IMPLICATIONS OF MEDICAL MARIJUANA</th>
<th>RATING 1-4</th>
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<tbody>
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<td>COMMUNICATES TOPIC IN MANNER APPROPRIATE FOR AUDIENCE &amp; OCCASION</td>
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<td>PROVIDES SUPPORTING MATERIAL (INCLUDING ELECTRONIC &amp; NON-ELECTRONIC AIDS) APPROPRIATE FOR AUDIENCE &amp; OCCASION</td>
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<td>USES ORGANIZATIONAL PATTERN APPROPRIATE TO TOPIC, AUDIENCE, OCCASION, &amp; PURPOSE</td>
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<td>RATING: 1 – POOR  2 – AVERAGE  3 – EXCELLENT  4 – THE DUDE ABIDES</td>
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QUESTIONS
Thank you,
Max “420” Beach