MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR MEDICAL MARIJUANA REGULATION
MEDICAL MARIJUANA REGULATORY PROGRAM

MEDICAL MARIJUANA PATIENT/PRIMARY CAREGIVER/HOME CULTIVATOR COMPLAINT FORM

Complaints regarding individuals who may be patients, primary caregivers, or patient cultivators of medical marijuana will be received pursuant to the Department's authority to enforce Article XIV, Section 1, and the associated regulations. Rules regarding the denial and revocation of medical marijuana identification cards can be found in 19 CSR 30-95.030.

Complaints and associated documents are public records, including all identifying information of the complainant. However, pursuant to Article XIV, Section 1.3(5), confidential information related to patients will be redacted before any public release of the complaint form.

A separate form should be submitted for each complaint unless the same individual(s) are involved. Once complete, submit the form and any attachments to: **mmcomplaints@health.mo.gov Attention: Patient/Caregiver Complaint.**

PATIENT/PRIMARY CAREGIVER INFORMATION

PATIENT/CAREGIVER NAME [1]	PATIENT/CAREGIVER LICENSE ID, IF KNOWN [2]

COMPLAINANT CONTACT INFORMATION

NAME [3]	DATE COMPLAINT FILED

ASSOCIATION TO PATIENT/CAREGIVER [4]	REPRESENTING ORGANIZATION AND TITLE, IF APPLICABLE [5]	CASE NUMBER

PHONE NUMBER	EMAIL

ADDRESS 1	ADDRESS 2

CITY	STATE	ZIP

CHECK ALL THE CATEGORIES THAT APPLY BELOW [6]

- ☐ Over legal possession limit pursuant to 19 CSR 30-95.030(5) Total amount of possession __________
- ☐ Distributing or selling medical marijuana
- ☐ Driving while impaired
- ☐ Un-lawfully in possession of Patient/Caregiver/Home Cultivation Card
- ☐ Over approved cultivation limits pursuant to 19 CSR 30-95.030(4) Total number of plants __________
- ☐ Cultivator's "enclosed, locked facility," as defined in 19 CSR 30-95.010 is in violation
- ☐ Medical marijuana from Dispensary not stored in its original packaging
- ☐ Conviction or guilty plea, or SIS for violation of 579.020, 579.065 or 579.068 RSMo or any similar of another state
- ☐ Other complaint

DATE(S) ACTION(S) OBSERVED [7]

PROVIDE DETAILS SUPPORTING THE COMPLAINT [8]

ARE SUPPORTING DOCUMENTS ATTACHED? ☐ Yes ☐ No
IF YES, PLEASE LIST.

SIGNATURE	DATE

Submit this form to: mmcomplaints@health.mo.gov Attention: Patient/Caregiver Complaint.

[1] The Patient/Caregiver name refers to the name of the individual the complaint is being filed against.
[2] The Patient/Caregiver license ID number refers to the number listed on the approved license. Include this information, if available.
[3] Name and contact information of person submitting complaint.
[4] Association to Patient/Caregiver refers to how the person submitting the complaint is associated with the patient/caregiver (i.e., neighbor, law enforcement, Social Services worker, etc.).
[5] Representing Organization and Title should be included when this form is being used by law enforcement or another agency to contact the program in an official capacity.
[6] Check the areas of rule the complainant believes the patient or caregiver is violating in Article XIV or associated rules in 19 CSR 30-95.
[7] Include all dates the actions for which the complaint is being filed were observed.
[8] Provide any comments or information that may help the Department review the potential violations.

AGENCY USE ONLY

FACILITY LICENSE & COMPLIANCE SECTION

DHSS STAFF ASSIGNED	DATE RECEIVED

REQUIRED INFORMATION PROVIDED	IF YES, SUPPORTING DOCUMENTS UPLOADED TO DATABASE	IF YES, DATE FORWARDED TO INVESTIGATION MANAGER
☐ Yes ☐ No	☐ Yes ☐ No	

IF NO, DATE RESPONSE SENT TO COMPLAINANT	COMPLAINT REDIRECTED TO ANOTHER STATE AGENCY	NAME OF RECEIVING STATE AGENCY
	☐ Yes ☐ No	

NAME OF RECEIVING AGENCY CONTACT	CONTACT EMAIL ADDRESS	CONTACT PHONE NUMBER

NOTES

INVESTIGATION MANAGER SECTION

INVESTIGATION MANAGER ASSIGNED	COMPLAINT CATEGORY
	☐ Category 1 ☐ Category 2

APPROPRIATE ACTION

☐ Initiate Investigation ☐ Not Pursuing Further ☐ Redirect to Another State Agency

IF INVESTIGATION INITIATED, COMPLETE THE FOLLOWING FIELDS

ASSIGNED COMPLIANCE OFFICER NAME	PATIENT SERVICES DIRECTOR NOTIFIED	DATE PATIENT SERVICES DIRECTOR NOTIFIED
	☐ Yes ☐ No	

IF NOT PURSUING FURTHER, COMPLETE THE FOLLOWING FIELD

RESPONSE SENT TO COMPLAINANT	DATE RESPONSE SENT TO COMPLAINANT
☐ Yes ☐ No	

IF REDIRECTED TO ANOTHER STATE AGENCY, COMPLETE THE FOLLOWING FIELDS

NAME OF RECEIVING STATE AGENCY	NAME OF RECEIVING AGENCY CONTACT
CONTACT EMAIL ADDRESS	CONTACT PHONE NUMBER
NAME OF RECEIVING STATE AGENCY	NAME OF RECEIVING CONTACT

NOTES