

Chapter 1: Understanding and Using the Oregon Medical Marijuana Act



This chapter describes the basic features of the Oregon Medical Marijuana Act (OMMA) including how to apply to the Oregon Health Division's Medical Marijuana Program. It also describes registry program management and renewal procedures as well as issues concerning the designated primary caregiver. Various concerns relating to growing and obtaining marijuana (Cannabis) for medical use are also considered.

What is the Oregon Medical Marijuana Act?

The Oregon Medical Marijuana Act creates an *exemption from Oregon State criminal law* for certain people to cultivate, use, possess and transport dried herbal Cannabis and live plants. The main (but not only) legal safeguard for Cannabis-using patients is registration in the Medical Marijuana Program managed by the Oregon Health Division. (For descriptions of the “*affirmative defense*” and “*choice of evils*” defense see Chapter 2.)

How do I apply?

In order for a patient to qualify for the registry program s/he must meet certain conditions:

First, the patient must suffer from a “*debilitating medical condition*” as defined in Section 3 of the Act. Debilitating medical condition means:

Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, or treatment for these conditions...

A medical condition or treatment for a medical condition that produces, for a specific patient, one or more of the following: cachexia; severe pain; severe nausea; seizures, including but not limited to spasms caused by multiple sclerosis; or (a)ny other medical condition or treatment for a medical condition adopted by the division by rule or approved by the division pursuant to a petition submitted pursuant to Section 14 of this Act.

(ORS475.302) ¹

Second, the patient must be under the care of a physician, (MD or DO) licensed to practice medicine in Oregon.



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The physician is the “*gatekeeper*” who must be willing to provide written documentation that marijuana may help alleviate the symptoms of the particular disease condition.



...the patient must submit the physician's written documentation ...brief application information, and an application fee of \$150 to the Oregon Health Division.



Patients who are unable or unwilling to grow their own Cannabis may, under OMMA, enlist the assistance of a *designated primary caregiver*.



The Oregon Medical Marijuana Act only covers patients and designated primary caregivers who are Oregon residents. *There is no interstate reciprocity* even though the entire West Coast of the U.S. now has similar laws on the books.

The physician is the “gatekeeper” who must be willing to provide written documentation that marijuana may help alleviate the symptoms of the particular disease condition. This written documentation is a “*medical opinion*” not a “*prescription*” for Cannabis. The patient may also use forms issued by the Oregon Health Division.

(See Appendix A for copies of the Medical Marijuana Program application forms.)

Third, the patient must submit the physician's written documentation (any paper or chart note with the required information may be used for this purpose), brief application information, and an application fee of \$150 to the Oregon Health Division. This program fee was established as part of the Oregon Health Division's rule-making hearings. Ballot Measure 67 required that the costs of operating the registry card system would be placed upon the patients who use it. Thus patients who use the program pay all fees. (This is an unfortunate burden for sick people, especially those who have may well have been bankrupted by the medical establishment. But it has a “silver lining”. The fee structure also isolates and protects the medical marijuana program from legislative cuts, which could have occurred in an attempt to destroy the Act.)²

Designated primary caregivers

Patients who are unable or unwilling to grow their own Cannabis may, under the OMMA, enlist the assistance of a *designated primary caregiver* (DPC). If a designated primary caregiver is used, the patient must also submit that person's name, address, date of birth, and copy of photo identification with the application materials. A designated primary caregiver may be added on (or removed) at any time during the year, at either party's discretion. Whenever a designated primary caregiver arrangement is agreed upon or terminated, the Oregon Health Division's Medical Marijuana Program staff should be notified in writing. Patients should expect to have this transaction confirmed by program staff. (There are instances where failure to notify the Division of a change in cardholder status has resulted in searches and inconvenience for registrants.) Also, any time a designated caregiver (or patient) changes their address, the Oregon Health Division should be notified. If the address growing Cannabis does not match the address on file with the Medical Marijuana Program the police will conduct further investigation.

The Oregon Medical Marijuana Act only covers patients and designated primary caregivers who are Oregon residents. *There is no interstate reciprocity* even though the entire West Coast of the U.S. now has similar laws on the books. The OMMA is not available to patients who are residents of another state. However, an Oregon patient may engage a caregiver who lives outside of Oregon if s/he wishes.

The designated primary caregiver should be made aware that the OMMA *would not* cover him/her in another State, although they would still receive a card from the Oregon Health Division certifying that they are cultivating for a patient in Oregon. As an example, if the patient lives in Portland Oregon, s/he could engage a caregiver living in Vancouver, Washington. The caregiver would receive a card from the Oregon Health Division but would not be protected from *Washington State* laws that ban cultivation and possession of Cannabis. If this person was in compliance with Washington law allowing the possession of a “60 day supply” s/he may be safe; however, this is far from certain since neither state’s medical marijuana law expressly includes anyone from the other state. To date, no court cases have addressed this interstate “reciprocity” issue. Thus the safest action would be for all parties to be registered *as patients* in each of their respective programs.

Applying to the registry program

In order to be properly registered in the medical marijuana program the patient must send all the required information to the State Health Division or drop it off at their county health department.³

The county health department is required to forward the application to the Oregon Health Division within “*five days of receipt*”. Any patient who drops off their application at the county health department should obtain a receipt showing the date exchanged and the document name. This is important because the applicant (patient) is covered by the legal protections of the registry card program *from the time the application is mailed to the Oregon Health Division or dropped off at the county health department*. The receipt is proof that the patient has applied to the registry card program. Patients are required to show this receipt (and hopefully a copy of the entire application) to police officers who request documentation. These legal protections cease if the application is rejected; however, incomplete applications are maintained as “pending” for some time, allowing the patient to safely complete the application procedure. Patients who have submitted an application, but have not yet received a card, must abide by all provisions of the law—possession and cultivation limits. Designated primary caregivers who have not received a card from the Oregon Health Division should consider themselves as *not* registered or legally protected. Unlike the patient, the caregiver *is not* legally registered at the time the application is submitted, only when the application has been approved. This could take weeks or months.

Once the Oregon Health Division receives the application it is date-stamped and reviewed for completeness. The program staff then contacts the physician, usually by telephone, to verify the accuracy of the information. The physician is asked to affirm that the applicant is presently under his/her care for a debilitating condition that qualifies. The physician is also asked to verify that they have provided the written documentation and that they agree that “*marijuana might help*”.



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The physician is asked to affirm that the applicant is presently under his/her care for a debilitating condition that qualifies.



The Oregon Health Division has no authority to “second-guess” the physician’s written documentation or judgement.

Sometimes physicians are squeamish or unsure about exactly what documentation is allowed or how to document it. The program staff frequently must provide information to physicians concerning their role and what the law allows the patient to do. However, the OHD has no authority to “second-guess” the physician’s written documentation or judgement.

If any application information is found to be fraudulently submitted then the application is rejected and is subject to criminal investigation by the Oregon State Police or the Oregon Health Division. A rejected applicant may not submit another application for a period of six (6) months.

The “Marijuana license” cards

Once the application has been verified as accurate and complete it is approved. When the \$150 fee has been received the Oregon Health Division issues and mails a *numbered certificate* and a *laminated wallet card* to the patient, and any caregiver. These documents contain application information for any and all registrants. The laminated wallet card has two sides. The Oregon Seal is on the front, along with the name and address of the patient or caregiver (whichever person the card is issued to). The Oregon Health Division’s telephone number and the date of issue and expiration also appear, as does the card number, printed in red.

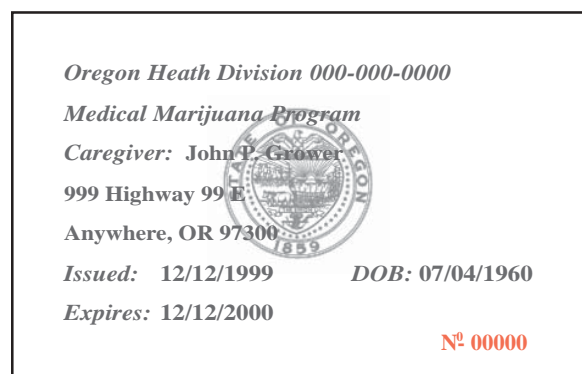
The back of the patient’s card has the corresponding information for the designated primary caregiver (if there is one). The name, address and date of birth of the caregiver is printed underneath the words “Oregon Health Division Medical Marijuana Program.” Once again, it is critical that the address of the caregiver match the location of the Cannabis “grow” since the caregiver is, by definition, cultivating Cannabis. If the caregiver’s address does not match with the grow location, police may telephone the Division for verification.



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Extra copies of the documents should be made and stored. In the event that a patient is contacted by law enforcement, s/he should show either document as proof of registration.



The Medical Marijuana Program Caregiver Card

An 8X9 inch, card-stock identification card is also sent to the patient and caregiver. This sheet contains “Record No.” and “Audit No.” in addition to all the information listed above. The record number is the database reference number. The audit number is the number given by the cashier to record the payment. Finally, the card-stock registration sheet also shows the Oregon Health Division letterhead.

These two documents are to be kept secure and available at all times for police inspection. Extra copies of the documents should be made and stored. In the event that a patient is contacted by law enforcement, s/he should show either document as proof of registration. The police should then contact the Oregon Health Division before conducting any further search or investigation, unless they have reason to believe that a crime is being committed. (Chapter 2 describes law-enforcement issues including “knock-and-talk” procedures.) Registered patients should remember that the law allows them to possess, use and grow Cannabis. Therefore, a police officer cannot use the presence of Cannabis or plants to justify a search.

The registry identification card is valid for one year from the date issued, and must be renewed annually to remain active. Renewal occurs when the patient completes and submits a renewal form and encloses the annual fee. (\$150 in 2000.) Renewing a registry card only requires the physician to confirm that the patient is still suffering from a debilitating condition. Information on the application should be updated at this time. If the information contained on the original application is still correct a new card is issued.

Possession limits and “legal” behaviors

Registration in the Medical Marijuana Program allows patients to grow up to seven Cannabis plants. It allows the caregiver to grow seven plants *if* the patient is not growing. There is some ambiguity regarding Cannabis grown at more than one location but in general as long as the number of plants between one patient/caregiver group does not exceed seven, the parties are protected. The law allows growers to flower up to 3 plants at a time and possess up to one ounce of dried (i.e. usable) Cannabis for each flowering plant. Patients may exceed the seven-plant limit if they obtain written documentation from the physician affirming that the greater amount is medically necessary. The Oregon Attorney General’s Guidelines also state that the law allows *more than seven plants* and recommends that the patient’s physician would need to agree that the greater allowance is legitimate. Unfortunately the OMMA does not clearly spell out a medical method for patients to establish greater need. Proving in court the greater need presupposes that the patient may have to get arrested and contest the charge.

If the patient (or caregiver) has three flowering plants then s/he is allowed three ounces of dried Cannabis. The law does not allow patients to flower more than three (3) plants at a time. Thus, if the grower has two flowering plants, s/he is allowed to possess two ounces of usable Cannabis. These limits do not appear to be a problem for police unless the total number of plants exceeds seven (7). If a caregiver is growing Cannabis for the patient at another location than the patient’s residence, the patient can only legally possess one (1) ounce of dried Cannabis. (See chapter 7 for a discussion of the convoluted legislative maneuverings that clouded the question of possession limits.)



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Under provisions of the Oregon Medical Marijuana Act Cannabis and plants may not be sold.



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The Oregon Medical Marijuana Act prohibits use of Cannabis in “public,” which includes highways, even if the patient is not driving.



Black-market Cannabis may also be contaminated with dirt, debris, bugs, seeds, other plants, or microorganisms. It may also be adulterated with harmful chemical residues like pesticides.

The Oregon Medical Marijuana Act allows patients or caregivers to transport up to one (1) ounce of dried Cannabis. Patients and caregivers may also transfer up to this amount of Cannabis (or up to seven live plants) to another registrant. Live plants are not “usable marijuana” and therefore they may weigh over an ounce. Since three of the seven plants must be flowering, patients may be at risk if they transport seven plants. To be safe, most patients only transport four plants at a time. Caution should be used to ensure that all parties involved in this transaction are registered with the program. If a registered patient gives Cannabis or plants to a non-registered person, s/he is breaking Oregon law. If the registered patient receives plants from someone who is not registered with the medical marijuana program, the unregistered person is breaking Oregon law. The patient is not. Even so, the patient is associating with someone who is committing a crime and wily prosecutors could manipulate the law by charging the patient with a “conspiracy” to commit a crime. For this reason, registered patients should deal with other registered patients or caregivers in any medicine or plant transactions.

Under provisions of the Oregon Medical Marijuana Act, Cannabis and plants may not be sold. Selling herbal Cannabis is a violation of the Medical Marijuana Program and may result in prosecution. However, since cultivation places the financial burden on the caregiver it *might* be interpreted that a patient may pay for the expenses incurred by the caregiver to grow Cannabis. (These expenses can be substantial and include electricity, fertilizer, soil, water, lights, fans, Carbon Dioxide [CO₂] generators, and timers.) Reimbursement for expenses may actually be allowed under the OMMA, but the issue has not been the subject of litigation as of 2001. There is a strong argument to be made that paying for electricity and equipment *is not* selling Cannabis but *assisting* in its cultivation. Until the issue gets litigated, patients and caregivers should understand that exchanging money for Cannabis attracts police attention. Not keeping records and using cash is easy. Carefully documenting electricity bills and other expenses takes a little work and time, but it shows exactly what the true costs of production are. The patient and caregiver should agree on what accounting method to use. In any case, patients and caregivers should carry their registry I. D. card with them any time they transport Cannabis or plants. (Medical Cannabis labels are provided in Appendix J to officially stamp the transported Cannabis as “medicine.”)

The Oregon Medical Marijuana Act prohibits use of Cannabis in “public,” which includes highways, even if the patient is not driving. Caregivers must also understand that the law does not permit them to use Cannabis unless they are also “patients.” The penalty in Oregon for simple possession of under an ounce of Cannabis is equivalent to a traffic citation and carries a *maximum* fine of \$1000.

Safely obtaining a supply of Cannabis

Although federal law bans possession and use of Cannabis its cultivation and sale is a multi-billion dollar business in the United States—another example in the long list of Drug War failures. In this difficult context sick people all over America struggle to meet their medical needs as they face the dual obstacles of dealing with the dynamics of illegal supply and federal prohibition.

Searching for and procuring illegal Cannabis forces many patients (and their families) into illegal drug markets. This is undesirable for several reasons: First, the quality of “black-market” Cannabis varies tremendously. Supplies are *economically* rather than *medically* driven. And, as with corporate dominance of American pharmaceutical and monetary systems, black-market systems have no particular regard for disease or suffering. Potency may vary significantly, from the nearly zero cannabinoid levels of Midwestern hemp, to the common low-to-medium quality Mexican Cannabis that gets bricked for shipping with little quality control. (It is worth noting that in areas of the country with large Cannabis industries, like Oregon, the quality of Cannabis is often superior. The demand for, and availability of high-potency Cannabis, unfortunately, also escalates the price.) Since there is no quality assurance, or cannabinoid assay, the patient has no idea of what s/he is paying outrageous prices to obtain. Black-market Cannabis may also be contaminated with dirt, debris, bugs, seeds, other plants, or microorganisms. It may also be adulterated with harmful chemical residues like pesticides. Imported Cannabis is often poorly cured, if at all. It continues drying after packaging and this can result in decomposition and bacterial infection.

Second, patients are searching for medicine among profiteers. Medical Cannabis patients are sometimes victimized. They are forced to pay extreme prices in much the same way as they now do for pharmaceuticals. The “market” price for medium-quality Cannabis ranges from \$40- \$100 for an eighth of an ounce. An ounce of high-potency Cannabis like “B.C. Bud” may cost \$400, higher than the price of gold! The price of Cannabis is a direct reflection of the supply and demand dynamics of illegal drug networks. The actual price to grow an ounce of high-potency “sinsemilla” ranges from \$10 to \$15 using metal halide lights. (Much less outdoors.)

Recreational users dominate the illegal Cannabis market. They have money and can afford to pay incredible prices. Patients can't. This undercuts the ability of patients to find and buy their medicine.⁵

Third, patients who associate with illegal drug networks are far more likely to be arrested and prosecuted because of this association.

For these reasons, patients are advised to avoid black-market Cannabis if possible. If an adequate safe supply is available from “the guy down the street” a patient will have to decide if the risks justify the benefits. Patients should deal with growers who they know and trust if at all possible.



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In order to minimize or eliminate black-market safety issues, the Oregon Medical Marijuana Act was written to include provision for cultivation and possession of plants.



The organization perhaps most responsible for assisting Oregon's patients is Voter Power which supports patients by providing information and assistance.



Ordering seeds by mail is another option that some patients are using. Cannabis seeds are widely available in many countries, especially in Europe.



Possession of viable Cannabis seeds is a federal crime in the United States. Patients who are apprehended attempting to smuggle seeds back into the United States face extreme legal consequences including forfeiture of assets and jail.



The belligerent attitude of the “feds” towards medical Cannabis will likely not cease until the laws surrounding Cannabis are changed in many individual states.

In order to minimize or eliminate black-market safety issues, the Oregon Medical Marijuana Act was written to include provision for cultivation and possession of plants. At this time, the only “legal” method for patients to obtain and possess Cannabis is to do it themselves under an umbrella of safety provided by the Oregon Health Division. The Oregon Medical Marijuana Act “allows” the transfer of plants between registered patients, aiding patients to provide their own supply. In Oregon, patient-to-patient supply networks are slowly establishing a network of safe communications allowing patients to grow their own supply. The overriding illegality of the herb, however, makes this process extremely difficult, and sometimes dangerous, since there are always people who are willing to exploit the law, as well as vulnerable patients, for profit.

With the continual threat of federal intervention hanging over the OMMA, patient-centered advocacy organizations that provide seeds and clones to registered patients have “sprouted” up. The organization perhaps most responsible for assisting Oregon’s patients is Voter Power which supports patients by providing information, assistance, and leadership. Other organizations like Medi-juana, and the Stormy Ray Foundation also work to support patients. (The “Oregon Resources” section provides contact information for most of the organizations in Oregon that assist patients.)

As statewide advocacy organizations develop, so too will patient networks. Many registrants know other registrants. They often provide clones or Cannabis to each other. This is smart, since networks of patients growing the same variety create “insurance” against any one patient’s crop loss. This arrangement also allows larger numbers of patients to compare the same strain.

Mail order seeds

Ordering seeds by mail is another option that some patients are using. Cannabis seeds are widely available in many countries, especially in Europe. Dozens of seed companies, selling hundreds of different strains advertise on the Internet and in publications like *High Times* magazine. On this continent, British Columbia, Canada has evolved a large commercial domestic Cannabis industry. Many Americans travel to Vancouver, B.C. to buy seeds, then smuggle or mail them back to the United States.

Again patients are in grave danger, not because of predatory drug gangs, but because of predatory police enforcement. What is perhaps worse is that police have the law on their side. Possession of viable Cannabis seeds is a federal crime in the United States. Patients who are apprehended attempting to smuggle seeds back into the United States face extreme legal consequences including forfeiture of assets and jail. As a result of the booming Cannabis industry in Canada, customs agents in Washington State are on heightened alert for anyone smuggling seeds or medicine. Patients should carefully evaluate the potential

risks of smuggling seeds into the United States. It is also a federal crime to use the U.S. Postal Service to send seeds through the mail although many people do so.

Where do we go from here?

Since Oregon's Legislators are generally fearful and insecure around the issue of medical Cannabis, it is unlikely that major legislative change will happen any time soon. In 2000, a group of medical Cannabis advocates met to discuss shortcomings and formulate a legislative bill. This working-group clarified language and suggested improvements to the OMMA. In any case, the OMMA in the year 2001 is equivalent to a patient in the intensive care unit on a respirator. Just keeping this program "alive" is progress. Probably the greatest single threat to the OMMA's security is federal interference. The belligerent attitude of the "feds" towards medical Cannabis will likely not cease until the laws surrounding Cannabis are changed in many states. Still, the Oregon State Health Division's Medical Marijuana Program remains the safest option because it removes patients from Oregon State criminal laws. Prior to 1999, these laws accounted for the majority of patient prosecutions.

Until the federal laws are changed, the safest way for Oregon patients to gain access to quality Cannabis strains for cultivation purposes is to network among themselves. In Oregon, patient and advocacy organizations serve as that basic structure. In the future when prohibitions against Cannabis are erased, these issues will not be a concern.

But for now, patients can ensure a safe, consistent supply of Cannabis, and stay out of legal trouble, by growing it themselves, never selling Cannabis and only exchanging plants, medicine and seeds with other registrants.



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Footnotes

¹ The Oregon Health Division added “Agitation due to Alzheimer’s disease” to the list of approved conditions in June 2000. (See chapter 7 for a description of the Debilitating Medical Conditions Advisory Panel.)

² Originally the fee was set at \$50 based upon guesses about how large or costly the program would be. Due to the statutory requirement that patient fees must fund the program, the Oregon Health Division decided upon a \$150 annual fee with the provision that the fee could be adjusted as the program evolved. This should eventually lead to a reduction in the fee as the program establishes a stable base.

³ Applications should be mailed registered mail to: Oregon Department of Human Services, Oregon Health Division, 800 NE Oregon Street, Suite 640. PO Box 14450, Portland Oregon 97293-0450. Attention: Medical Marijuana Program. A pre-addressed envelope is enclosed in the application packet. The Health Division sends a confirmation letter after receiving the application.

⁴ The OMMA has no provision for monitored cultivation in larger facilities like the Cannabis resource centers in California. Federal prohibition, which makes large grow operations vulnerable to interference from various agencies of the federal government, has contributed to implementation difficulties in California.