

HB 3355

Testimony in Support - House Committee on Economic Development

	Patients	Year to Year drop	Total drop	Caregivers	Year to Year drop	Total drop	Growers	Year to Year drop	Total drop	Grow Sites	Year to Year drop	Total drop
01/2015	70,139	-	-	35,064	-	-	46,601	-	-	35,765	-	-
01/2016	↑ 77,155	↑ +10%	↑ +10%	35,736	↑ +2%	↑ +2%	46,812	↑ +0.5%	↑ +0.5%	32,171	↓ -10%	↓ -10%
01/2017	↓ 67,141	↓ -13%	↓ -0.4%	28,368	↓ -21%	↓ -19%	36,354	↓ -22%	↓ -22%	26,631	↓ -17%	↓ -26%
01/2018	↓ 50,400	↓ -25%	↓ -29%	20,030	↓ -29%	↓ -43%	25,615	↓ -30%	↓ -45%	20,025	↓ -25%	↓ -44%
01/2019	↓ 31,251	↓ -38%	↓ -65%	13,013	↓ -35%	↓ -63%	14,673	↓ -43%	↓ -69%	12,408	↓ -38%	↓ -66%

65.75%

Total average drop in all categories from January 2015 to January 2019

Total number of patients being grown for January 2019

4,509*

4,509 patients x 6 plants

27,054 plants

27,054 plants x 1 lb./plant

27,054 lbs.

x 1.5 lbs./plant

40,581 lbs.

OMMP usable marijuana into the OLCC system 360 lbs.

*This is an average of Patients/Grow Site and Growers w/Multiple Patients

Transfer Authorization Form
Medical marijuana caregiver or grower to DISPENSARY

(To be completed by and signed by the O MMP patient.)

Note: Use this form to authorize transfer of your usable marijuana, immature plants and seeds. Only one individual can be authorized per form.

Section 1 — Patient authorizing transfer

Name: _____ Phone number: _____

OMMP card number: _____ OMMP card expiration date: _____

My *(check one)*: caregiver grower

Is authorized to transfer *(check all that apply)*: usable marijuana immature plants seeds

Section 2 — Person authorized to make transfer

Name: _____ Phone number: _____

OMMP card number: _____ OMMP card expiration date: _____

Section 3 — Signature and dispensary information *(required)*

I, _____, *(patient)* authorize the above-named individual to transfer my usable marijuana, immature plants and seeds to the following registered **dispensary**:

Dispensary name:	MMD number:
Dispensary physical address:	
City/State/ZIP:	

Date authorization expires *(if different than expiration on patient's O MMP card)*: ____ / ____ / ____

I understand the product will no longer be my property after transfer is complete. The product will be returned to me if tests are positive for pesticides.

Patient signature *(required)*: _____ Date: _____

Note: The dispensary must keep the original copy of this form on file. Other parties should also keep a copy for their records.