

Health Systems Quality Assurance Office of Customer Service

PO Box 47857, Olympia, WA 98504-7857

Complaint Intake Form Medical Cannabis Consultant

# Date Complaint Filed: Complainant Information:

Name:

(First) (Middle) (Last)

|  |  |  |  |
| --- | --- | --- | --- |
| Physical Address:  |   |   |   |
| (Street Address) | (City) | (State) | (Zip) |

Mailing Address (if different than above):

(Street Address) (City) (State) (Zip)

Phone: ( ) -

Home:

Cell:

Work:

Email:

Medical Cannabis Recognition Card # (if you are a patient in the database):

**Medical Cannabis Patient Information (if complainant filling out on behalf of someone else):**

Are you filing this report out on behalf of a medical cannabis patient that you are the designated provider for?

Yes No If yes, please complete the following:

# Complainant Information:

Name:

(First) (Middle) (Last)

Physical Address:

(Street Address) (City) (State) (Zip)

Mailing Address (if different than above):

(Street Address) (City) (State) (Zip)

Phone: ( ) -

Home:

Cell:

Work:

Email: Medical Cannabis Recognition Card # (if you are a patient in the database):

# Information about the Medical Cannabis Consultant:

Please provide as much information as possible regarding the consultant(s) and/or the medically endorsed store the consultant works at.

Consultant Name: Store Name:

|  |  |  |  |
| --- | --- | --- | --- |
| Physical Address:  |   |   |   |
| (Street Address) | (City) | (State) | (Zip Code) |

Store Phone: ( ) -

Date(s) of visit to the Medically Endorsed Store:

**For internal administration purposes only:**

Employment status with the medically endorsed store: Current Employee Former Employee Never an Employee

# Complaint:

Please describe your complaint in the space below. Include the name, title and phone number of other customers, witnesses or staff involved in the incident (if applicable).

Have you filed a complaint with anyone at the store?

Yes No If yes, with whom? Have you received a response? Yes No

Date:

Comments:

Have you reported this to or filed a complaint or action with any other agency or organization? For example law enforcement, Washington State Liquor and Cannabis Board, etc.

Yes No

If yes, with whom?

Date:

Have you received a response? Yes No

Comments:

Return this completed form via mail or email to: Washington State Department of Health

Health Systems Quality Assurance

Complaint Intake Unit PO Box 47857

Olympia, WA 98504-7857 HSQAcomplaintintake@doh.wa.gov

If you have questions, please call 360-236-2620. Additional information regarding the complaint and disciplinary process is available on our web site at [www.doh.wa.gov](http://www.doh.wa.gov/).