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? ______________________ Date: __________

Have you received a response? Yes ☐ No ☐

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.