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Health Systems Quality Assurance

Office of Customer Service

PO Box 47857, Olympia, WA 98504-7857

**Complaint Intake Form  
Medical Marijuana 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 Marijuana Recognition Card # (if you are a patient in the database):

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

Are you filing this report out on behalf of a medical marijuana 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 Marijuana Recognition Card # (if you are a patient in the database):

**Information about the Medical Marijuana 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:

Store Address:                           
 (Street Address) (City) (State) (Zip)

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](mailto: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 website at [www.doh.wa.gov](http://www.doh.wa.gov).