

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

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).