Medical Marijuana Licensee Incident Report Form

Updated 11/07/2019

This document is intended for use by licensed dispensaries reporting any incident required under rule. A separate form must be filed for each incident type. The instructions below should be followed to submit a request:

1. Complete all fields on this form. Contact information in sections A-8, A-9, and A-10 are referencing the person filing the incident report form.
2. Print and sign the form.
3. Scan the completed form and save to your computer in a PDF format compatible with the latest version of Adobe Reader.
4. Login into the Board of Pharmacy's website: https://www.pharmacy.ohio.gov/upload to upload the completed form. You will need your license number (MMD.07 followed by 5 digits) and eLicense security code to access the Compliance Upload Portal page.
5. Once logged in, complete all fields on the web page.
6. Follow the instructions to upload and submit the completed Medical Marijuana Licensee Incident Report.

Section A - Licensee Information			
A-1. Dispensary Name:		**A-2. Dispensary License Number:**	
A-3. Dispensary Facility Address:			
A-4. City:	**A-5. State:** OHIO	**A-6. Zip Code:**	**A-7. County:**
A-8. Licensee Contact Person:		**A-9. Designated Representative (Y/N)** YES NO	
A-9. Licensee Contact Phone Number:	**A-10. Licensee Contact Email Address:**		

Section B – Incident
B-1. Incident Type:
B-2. Date/Time of Incident: **(For example: dd/mm/yyyy / 10:00 am)**

Section B Cont'd – Description of Incident

B-3. Description of Incident: *(Instructions: Description of the incident shall include, but not limited to, relevant date(s), chronological explanation of events, parties involved, final outcome, and resolution, if applicable)*

Section C – Signature and Attestation

I declare under penalties of falsification as set forth in Chapters 2921., 3715., 3719., 3796., and 4729. of the Ohio Revised Code that I am the person identified in Section A of this form. I hereby acknowledge I am authorized to sign on behalf of the dispensary identified in Section A of this form and that this form is true, correct, and complete. I hereby acknowledge that if the authority sought is granted, the Employee shall submit to the jurisdiction of the State of Ohio Board of Pharmacy and to the laws of this State for the purpose of enforcement of Chapters 2925., 3715., 3719., 3796., and 4729. of the Ohio Revised Code and all related laws and rules. This form must be printed and signed with an original, wet-ink signature. ***Electronic or digital signatures are not acceptable.***

C-1. Printed Name:	**C-2. Phone Number:**
C-3. Signature:	**C-4. Date Signed:**