Unauthorized Medical Cannabis Possession Report

A licensed peace officer must complete this form to report as required under Minnesota Rules part 4770.4010 any reasonable suspicion of an individual’s unauthorized possession of medical cannabis.

Incident Information

Date of incident: ____________________________ Time of incident: ____________________________
Location of incident: ___________________________________________________________________
Name of person found in possession of medical cannabis: ___________________________________________________________________

Medical Cannabis Label Information

Name of person authorized to possess medical cannabis: ___________________________________________________________________
Registry identification number of authorized individual: ___________________________________________________________________
Medical cannabis product manufacturer: ___________________________________________________________________
Medical cannabis product name: ___________________________________________________________________
Medical cannabis chemical composition: ___________________________________________________________________
Medical cannabis form:  
☐ Pill/capsule ☐ Bulk oil
☐ Liquid (tincture/oral suspension) ☐ Topical application (patch/lotion)
☐ Vaporizer pen

Incident Circumstances

☐ Emergency call  
☐ Routine traffic stop  
☐ Call of concern  
☐ Other, explain:  
Description of incident circumstances:
Was there any damage to medical cannabis or medical cannabis containers?

☐ No  ☐ Yes (if yes, please explain below)

Quantity of medical cannabis obtained:

___________________________________________________________________________________

Is all medical cannabis accounted for?

☐ Yes  ☐ No (if no, please explain below)

Local law enforcement agency that took custody of medical cannabis?

___________________________________________________________________________________

Date of transfer of medical cannabis to local law enforcement: _______________________________

Time of transfer: ______________________________________________________________________

**Individual Completing This Report**

Individual’s name and title:______________________________________________________________

Individual’s place of employment: _______________________________________________________

Telephone number for individual completing this report: ______________________________________

Email for individual completing this report: _________________________________________________

Minnesota Department of Health
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To obtain this information in a different format, call: 651-201-5598.