File No: _______

________ COURT OF JUSTICE

Criminal Division - ________________ Region)

Between:

____

Applicant/Accused

and

Her Majesty the Queen

Respondent/Plaintiff

RECORD OF APPLICATION AND CONSTITUTIONAL ISSUE

Pursuant to S.8(2)(a) of the

Constitutional Question Act

TABLE OF CONTENTS

1. Notice of Application and Constitutional Issue.....2

2. Applicant's factum...............................5

For the Applicant/Accused:

Name: ___________________________________

Address: ________________________________

Tel/fax? ________________________________

Email: __________________________________

For the Respondent:

Ministry of Justice

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File No: _______

________ COURT OF JUSTICE
Criminal Division - ________________ Region)

Between:

____

Applicant/Accused

and

Her Majesty the Queen

Respondent/Plaintiff

NOTICE OF APPLICATION AND CONSTITUTIONAL ISSUE
Pursuant to S.8(2)(a) of the
Constitutional Question Act

TAKE NOTICE that on Jan 15 2018 will be heard a motion at the Abbotsford Courthouse seeking an Order declaring:

A) the MMAR-MMPR-ACMPR marijuana medical exemption regimes invalid for violating the accused's S.7 Charter right.

B) Controlled Drugs & Substances Act:
S.4, S.5, S.7 prohibitions on marijuana of no force and effect while the exemption is unconstitutional pursuant to R. v. Parker (2000) and R. v. Krieger (2000);

Accused further seeks an Order:

C) staying the charges against the accused, and if jurisdiction:

D) striking the word "marijuana" from CDSA Schedule II;

E) expunging all convictions registered since Aug 1 2001;

F) returning the seized Controlled Substance be returned to Applicant pursuant to S.24 of the CDSA.

AND FOR ANY ORDER abridging any time for service or amending any error or omission as to form, color, font, margins, content which the Honourable Justice may allow.

Dated at ___________________ on ____________ 201__.

____

Applicant/Accused Signature

Name: ___________________________________

Address: ________________________________

Tel/fax? ________________________________

Email: __________________________________

CC: Provincial Attorney-General

HER MAJESTY THE QUEEN **V.** ______________________

Plaintiff **Accused**

________ COURT OF JUSTICE

(Criminal Division)

Between:

____

Applicant/Accused

and

Her Majesty the Queen

Respondent/Plaintiff

NOTICE OF APPLICATION

AND CONSTITUTIONAL ISSUE

Pursuant to S.8(2)(a) of the

Constitutional Question Act

For the Applicant/Accused:

Address:______________________

____

Tel/fax: __________________________

Email: __________________________

File No: _______

________ COURT OF JUSTICE

Criminal Division - ________________ Region)

Between:

____

Applicant/Accused

and

Her Majesty the Queen

Respondent/Plaintiff

FACTUM ON CONSTITUTIONAL ISSUE
Pursuant to S.8(2)(a) of the
Constitutional Question Act

PART I - FACTS

1. ACCUSED seeks an an Order declaring:

A) the MMAR-MMPR-ACMPR marijuana medical exemption regimes invalid for violating the accused's S.7 Charter right.

B) Controlled Drugs & Substances Act S.4, S.5, S.7 prohibitions on marijuana of no force and effect while the exemption is dysfunctional pursuant to R. v. Parker and R. v. Krieger (2000);

2. Accused further seeks an Order:

C) staying the charges against the accused, and if jurisdiction:

D) striking the word "marijuana" from CDSA Schedule II;

E) expunging all convictions registered since Aug 1 2001;

F) returning the seized Controlled Substance be returned to Applicant pursuant to S.24 of the CDSA.

3. GIVEN available US Government statistics showing zero deaths attributed to the use of the cannabis plant;
Given preponderant available evidence from US insurance companies in states that have recently legalized marijuana showing that "high" drivers have less accidents;
GIVEN the University of Saskatchewan's 2006 study showing cannabis use promotes neurogenesis, new brain cell growth, useful for Alzheimer's and dementia victims;
GIVEN preponderant available evidence showing that marijuana oil kills cancer and with a rise in cancers from the Fukushima nuclear fallout we're being exposed to looming expected;
GIVEN the preponderant available evidence forces Health Canada to allow the use of cannabis for so many varied illnesses,
GIVEN dozens of distinct bureaucratic impediments in the MMAR-MMPR medical exemption regimes that reduce the chances of a patient's good health and survival making both regimes irreparably and unconstitutionally illusory pursuant to S.7 Charter Right to Life.

4. The Expert Witness Report will conclude that if cannabis marijuana is good for you once you're sick, it was probably good for you before you got sick. Not using cannabis for prevention of all the illnesses it's good for once you get them before you get them reduces the chances of survival. And that the neurogenesis of new brain cells reported in the 2006 University of Saskatchewan study is a benefit too important to prohibit.

5. Out of the ten Canadians who die from epileptic seizures every day, four knew they were epileptic and could have been alive today if all epileptics had been granted the same protection of right to life as the Court of Appeal granted Terrance Parker to possess a joint. 13 years since the Parker decision, that's almost 20,000 epileptics who would have survived had their anti-seizure medication not been prohibited.

6. If it's beneficial when you get sick, not getting it on demand reduces your chances of survival. Health Canada has relegated the MMAR Exemption Applicants who died during the delay in application processing to their "Dormants File," the wrong word for 6 feet under. Once the Defendant elicits from Health Canada the number of "dormant" applicants to date whom they could not find alive, the reduction of their chances of survival due to the delay will have been established. In every case where cannabis has a life-saving effect, the bureaucratic delay in obtaining an exemption increases the chance of ending up in Health Canada's "Dormants" file.

METHODOLOGY USED

7. By inference and deduction, and with an analysis of the preponderance of "anecdotal evidence" available, each constitutional violation alleged ("Tort") will be shown to reduce the chances of health and survival more than help.

8. An honest anecdote is an honest datum. More and more honest anecdotes become more and more precise data. To say that the measurement of a preponderance of available data may be dismissed because it is "anecdotal" is to fail to grasp the whole purpose of statistics, to derive honest information from more and more anecdotal data.

The theory of the constitutional challenge is that the Medical Marijuana regimes since 2001 have offered illusory access and supply and that, as ruled in R. v. J.P. [2003], the R. v. Parker [2000] decision decided the Possession Prohibition is invalid absent a valid exemption. The R. v. Krieger [2003] decision ruled the Production Prohibition is invalid absent a valid medical Exemption.

4. Applicant will offer 2 different sets of grounds:
- harms apparent in the legislation;
- harms attested to by the witnesses.

5. The first and foremost harm attested to by witnesses will be the same as that presented in R. v. Mernagh, 2011 ONSC 2121 canlii.ca/en/on/onsc/doc/2011/2011onsc2121/2011onsc2121.html

6. Superior Court Justice Taliano struck down the S.4 Possession and S.7 Production of Marijuana prohibitions after finding the MMAR medical exemption illusory on evidence showing lack of doctor participation. The Ontario Court of Appeal overturned that decision stating there was no evidence presented that the doctors did not have valid medical reasons for refusals. The Crown stayed Mernagh's charge in order to avoid losing again.

7. My motion presents the same kind of testimony as that in Mernagh showing how doctors refused but will also include the non-medical reason they used to reach their medical decisions. It is a "Mernagh Plus Why" refused constitutional challenge.

8. Though I will be stressing the Mernagh Plus Why No Doctors ground that was declared total failure by itself, that Justice Taliano invoked Parker in striking down the S.4 Possession and S.7 Production offences while the Exemption

was deficient, I will also be proffering other flaws in the medical regimes that make it illusory.

PART II - UNCONSTITUTIONAL ISSUES RAISED:

UNDER ALL THREE MMAR, MMPR, ACMPR REGIMES

16. The following constitutional violations are alleged under the 3 MMAR, MMPR, and ACMPR exemption regimes which unreasonably restrict access and/or supply:

1) MMAR S.4(2)(b); MMPR S.119 and ACMPR S.8(1) require a medical document from recalcitrant or not-available family doctors.

2) The three regimes failed to provide DIN (Drug Identification Number) for affordability and insurance coverage.

3) MMAR S.13(1), S.33(1), s42(1)(a); MMPR S.129(2)(a) and ACMPR S.8(2) require annual renewals for permanent diseases and then short-change them on the year.

4) MMAR S.65(1); MMPR and ACMPR S.199(1)&(2), S.200(1)&(2) compel exemptees to destroy unused cannabis before receipt of new batch with no refund.

5) MMAR S12.(1)(b), S.32(c), S.62(2)(c), S.63(2)(f); MMPR S.117(1)(c) and ACMPR S.43(1), S.46(1), S.184(d) allow the Ministry to revoke the patient's permits for non-medical reasons.

6) MMAR, MMPR and ACMPR fail to exempt patients from the CDSA S.5(1) prohibition on trafficking for trading and sampling different strains for different pains and gains in production.

7) MMAR, MMPR, ACMPR fail to exempt transformers of marijuana to edibles and oils the prohibition on which was ruled unconstitutional in R. v. Smith [2015] by the Supreme Court.

8) Industrial Hemp Regulations SOR/98-156 CDSA stifles hemp production by defining "industrial hemp" as not containing more than 0.3% THC w/w.

UNDER THE MMAR AND ACMPR

17. The following constitutional violations are alleged under the only the MMAR and ACMPR exemption regimes:

9) MMAR S.32(e) and ACMPR S.184(b) prohibit more than 2 licenses/grower.

10) MMAR S.32(d) & S.63(1) and ACMPR S.184(c) prohibit more than 4 licenses/site.

11) MMAR S.30(1) and ACMPR S.190 limits the number of plants ensuring no seasonal economies nor respite from constant gardening.

12) MMAR and ACMPR fail to license any garden help.

13) MMAR S.35(b), S.37(2d), S.39(1c) and ACMPR S.174(3)(a), S.176(2)(a), S.177(4)(a) make a Registered Person or Designated Person ineligible for a production license if they have been convicted of a "designated cannabis offence" within the preceding 10 years.

14) Under both regimes with personal production, Health Canada takes time to make intimidating phone calls to doctors trying to convince them to reduce their prescriptions and complaints to the doctor's association to pass along to the doctor! No problem when buying from an L.P.

15) Applications to produce took 4 weeks under the MMAR and now take up to 30 weeks under the ACMPR. Applications to renew took far less under the MMAR but take up to 16 weeks under the ACMPR. Applications to amend took under 4 weeks under the MMAR and now take up to 13 weeks under the ACMPR.

UNDER THE MMPR AND ACMPR

18. The following constitutional violations are alleged under the MMPR and ACMPR exemption regimes:

16) MMPR S.117(1)(c)(i): "The Licensed Producer must cancel if there are reasonable grounds to believe that false information has been submitted;"
ACMPR S.117(2): "must cancel without delay if LP has verified the existence of the ground in a "reasonable manner."
ACMPR S.117(3): "has reasonable grounds that a ground exists."

17) MMPR S.117(4) and ACMPR S.139(3) let Licensed Producers cancel patient's registration for undefined "business reason;"

18) MMPR S.117(7), S.118 and ACMPR S.139(7) prohibit the Licensed Producer from returning or transferring the medical document back to the patient;

19) MMPR 20) S.5(c), S.73(1)(e), S.123(1)(e), S.130(2) and ACMPR S.6(1)(d), S.178(2)(f)(ii), S.189(1)(e) prohibit possession or delivery of more than 30-days or 150 grams.

20) L.P.s cannot supply fresh leaves, juice, oil.

21) L.P. Prices Unaffordable

PART III - ARGUMENTS

UNDER ALL THREE MMAR, MMPR, ACMPR REGIMES

1) RECALCITRANT DOCTORS AS GATEKEEPERS

MMAR S.4(2)(b): "An application under subsection (1) shall contain a medical declaration made by the medical practitioner treating the applicant;"
MMPR S.119 "Applicant must include original of their medical document."
ACMPR 8(1) A medical document provided by a health care practitioner to a person who is under their professional treatment must indicate...

19. Applicant adopted the facts established by Taliano J. in R. v. Mernagh not with respect to there being "not enough doctors" but with respect to there being some doctors allowed to opt out of the MMAR for non-medical reasons.

20. On Apr 11 2011, the Ontario Court of Appeal ruled in R. v. Mernagh:

> **"[9] On the Charter application, Mr. Mernagh did not argue that the MMAR are unconstitutional as they are drafted. Rather, he argued that the MMAR are unconstitutional as they are implemented because physicians have decided en masse not to participate in the scheme."**

21. The Court pointed out there was no evidence of the number of people who need it, the number who asked for it and were refused, no numbers proving a boycott.

22. The Court further noted:

> **"[28] In answer to the argument of the Hitzig appellants that the concerns of the medical profession and its governing bodies regarding the role of doctors as gatekeepers would prevent doctors from signing the requisite forms and thereby prevent worthy individuals from obtaining a licence, the Court found that on the record before it the argument was answered by Lederman J.'s findings that despite the concerns of central medical bodies, a sufficient number of individual physicians were authorizing the therapeutic use of marihuana that the medical exemption could not be said to be practically unavailable (Hitzig, supra at para. 139)."**

23. So even if there had been a boycott by a vast majority of doctors, in 2003 Hitzig had ruled the medical exemption was "not practically unavailable" with even only 1 doctor in 100 participating.

24. Unlike Mernagh, Accused does not argue there was boycott of doctors making his access illusory, he has argued the regimes permit doctors to refuse without any contra-indications of use, with non-medical reasons, that make access illusory.

25. The Court of Appeal ruled that the Mernagh witnesses had not given evidence that the refusing doctors had not had valid medical reasons contra-indicating use. To fill this

gap, the patient witnesses herein, many with qualifying diseases testified to their angst-filled searches for a doctor to sign and the non-medical reasons the doctors had used to refuse:

"I don't know enough about marijuana."

"I don't like the forms."

"I don't need the calls from Health Canada."

"I'm not interested" because of my Medical Association."

"I'm afraid for my practice!"

"I don't want to be known as a pot doctor."

"I don't know you well-enough."

"I don't want to be liable should you commit a criminal act under the influence!"

"I don't do that. Have some narcotics instead."

"Marijuana is not approved with a DIN."

26. The Mernagh evidence is also replete with these non-medical reasons for refusals though that evidence was wasted in a futile attempt to prove a doctor boycott. Accused submits that an exemption that is "not practically unavailable" because some sign is not enough, it is not practically available when some don't sign.

27. The Mernagh Court of Appeal wrote:

> **"[147] Much of the evidence relied on by Mr. Mernagh to support his claim that the defence in the MMAR is illusory does not link physician non-participation in the MMAR or individual refusals by physicians to provide the necessary declaration with any kind of governmental action. A doctor who refuses to provide the necessary declaration because he or she is not satisfied that the criteria in the regulations are met, does not feel sufficiently knowledgeable about the effects of marihuana, is unfamiliar with the patient, or views the**

use of marihuana as medically contra-indicated, is certainly limiting the availability of the medical exemption contemplated in the MMAR. However, that decision is not attributable to the government or any form of governmental action. Nor, in my view, can the physician, by exercising the gatekeeping role demanded of the physician by the legislation, be said to make the defence created by the legislation illusory. Refusals based on the doctor's exercise of his or her judgment are inherent in the defence created by the MMAR."

28. One would presume refusals would be based on the doctor's exercise of his or her MEDICAL judgment, not for the myriad of lame non-medical excuses listed above. The Court presumed doctors would be professional and not let their clients die, that doctors would do right even if given a responsibility they don't want to bear. But they do let their clients die with no contra-indication of marijuana use. Every epileptic having a fatal seizure without access to a joint is testament to his doctor not doing his research. What medical reasons could a doctor have to refuse an epileptic with a permanent disease when the Parker decision established the Charter Right not to be denied its anti-seizure efficacy? From 100 seizures a day, after a lobotomy and lobectomies failed to help, Terry Parker has not had an epileptic seizure in all the years that he has continued smoking cannabis since his constitutional exemption expired in 2001 and before.

29. Of course, if cannabis was contra-indicated or the patient had not satisfied the criteria in the regulations, refusal is justifiable. But the doctor cop-outs listed above are not medical judgments.

30. To plead incompetence can never be deemed professional when it comes to the least dangerous herbal treatment with the best safety record in history? "Never killed anyone, works for others but I haven't studied up so find someone who has" is no medical judgment.

31. The doctor refusing for being afraid of his medical association, afraid of his insurance company, afraid of Health Canada calls, afraid of being called a "pot doctor," afraid of the mountain of paperwork or afraid for his practice is not making a medical judgment.

32. That the doctor is unfamiliar with the patient is irrelevant when the doctor should be familiar with the patient's condition. If a medical history says Epilepsy, how much more does the doctor need to know? Why are some doctors willing to authorize epileptics upon one consultation, even by Skype video-call, yet others need a more personal tete-a-tete?

33. That the doctor could believe he would be liable for crIminal acts committed "under the influence" shows the silliness of some non-medical reasons.

34. That the doctor will only prescribe addictive narcotics when the patient wants to try non-addictive herbal treatment violates the patient's right to decide established in Morgentaler. If this were any new chemical drug, doctors would be expected to do their professional research when the patient asks about it, not refuse.

35. Though most witnesses eventually found doctors to sign, some patients never did and one was thrown out of the doctor's office. There are other reports of such "no more

family doctor" refusals. Applicant submitted that when the patient is thrown out by the doctor, that doctor may be presumed to not be signing for any of the other patients in his practice. Minus the 5 million Canadians without family doctors, 60,000 doctors serving 30 million Canadians is 500 patients per practice. So it's safe to conclude that a doctor's whole 500-patient practice remains un-served, not only that particular patient being currently un-served. And if the recalcitrant gate-keepers are not opening the gates, it's the regimes' fault for making recalcitrant doctors gatekeepers. The patient has no use for his doctor's medical opinion when the doctor admits he's ignorant of the treatment. Installing reluctant and willfully-ignorant as gatekeepers can only impede access.

36. Taliano J. pointed out:

> **"[147] With the leadership of the medical profession being so adamant in its opposition to its proposed role as gatekeeper, it is little wonder that the profession has not been supportive of the MMAR and the patient witness evidence of this lack of support becomes understandable."**

37. The Crown argues it is not the legislation's fault that the doctors may not be signing in large numbers. Taliano J. cited the resistance by medical associations to being appointed gate-keepers over something they knew nothing about. Legislation appointing someone ignorant of the treatment is tantamount to appointing a monkey as gate-keeper and noting the fact the monkey sometimes opens the gate means the exemption is "not practically unavailable!" For the 5 million Canadians without a family doctor, it is completely practically unavailable and they must remain completely unserved by the present regime with recalcitrant doctors as gate-keepers.

38. The Court of Appeal should not need the numbers to logically infer that doctors were boycotting the regime when so many medical associations had been noted in opposition as well as the testimony of the Mernagh witnesses to the refusals of many doctors to serve them, and implicitly, their 500-patient practices. Fortunately, Applicant objects to doctors being able to opt out at all without medical contra-indications of use.

39. Justice Taliano finally concluded:

> **"[327] While that approach was justified and feasible in Hitzig, the same cannot be said of the present case. Because the court in Hitzig only found certain and isolated sections of the MMAR to be invalid, it was able to specifically address those provisions in its remedy without altering the overall significance of the legislation. However, in the case at bar I have found that the requirement for a medical doctor's declaration has rendered the MMAR unconstitutional. This requirement infects numerous sections of the MMAR."**

40. On the basis of the similar evidence as Mernagh but with the gap on why the doctors refused filled, the requirement of ignorant recalcitrant doctors is unnecessary and unconstitutional when simple proof of illness should be the only medical judgment needed.

41. The health improvements all patient witnesses attest to do condemn the doctors who wouldn't or couldn't do their duty in exercising the gatekeeping role demanded of the physician by the legislation. Once demanded of them, unprofessional incompetence and bias aren't proper gate-keeping for anyone's medicine. The herb is too benign to need more regulations than tomatoes.

2) NO DRUG INFORMATION NUMBER

42. One cardiologist refused because marijuana was "not an approved medication" without a DIN Drug Information Number.

43. Not being an approved substance has been used as a reasonable rationale to allow some doctors to assuage their conscience when they opt out of their responsibility to their patients. Cannabis can never be approved until it gets a DIN. Not having a DIN also forecloses any hope of financial coverage. The lack of DIN remains in the MMPR.

44. On Feb 2, 2017, the Nova Scotia's Human-Rights Board ruled that Godron Wayne Skinner, a man suffering from chronic pain, must have his marijuana prescription paid for by his employee-insurance plan. No DIN is the reason for the ruling.

3) ANNUAL DOCUMENTS FOR PERMANENTLY ILL

MMAR S.13(1), S33(1), S.42(1)(a): "ATP Subject to subsection (2), an authorization to possess expires 12 months after its date of issue..."
MMPR S.129(2)(a) "The period of use referred to in paragraph (1)(e) must be specified as a number of days, weeks or months, which must not exceed one year;
ACMPR S.8(2) The period of use… must not exceed one year.

45. Doctors know that instead of prescribing cannabis once and perhaps never seeing an epileptic again, the patient would have to come back every year for him to fill out the forms. Imagine how all that yearly form-filling would affect any practice for epilepsy! Instead of exempting them all once, it's all of them every year! Say a doctor has 500 epileptic patients and exempts them 100 per year of 5 years.

When he's done he hasn't had to fill out 100 forms per year but 100, 100+100 renewals, 100+200 renewals, 100+300 renewals, 100+400 renewals totaling 1,500 forms filled out with 500 more every year thereafter when it should have been only 500 forms once. Over a 10-year span for 1,000 epileptics, that would take 5,500 forms filled out instead of 1,000 once. Annual renewals for permanent diseases is a waste of the patient', doctor's, and regulator's time.

4) DESTRUCTION OF SUPPLY

MMAR S.65(1): "If an authorization to possess expires without being renewed or is revoked, the holder shall destroy all marihuana in their possession."
MMPR S.5(c), S.73(1)(e), S.123(1)(e), S.130(2)
ACMPR S.199(1)&(2), S.200(1)&(2)

46. The regimes order that marijuana be destroyed without compensation upon expiry of any exemption without renewal or temporary over-supply by the prohibition on possession of more than the 30 day dosage or 150 grams. Should a patient under-use and have some spare at the end of the month, it is prohibited to possess his new supply without destroying the remainder of his old supply. But should a patient over-use and lack some at the end of the month, bad luck, can't get any more.

5) BUREAUCRATIC CANCELLATIONS

MMAR S12.(1)(b), S.32(c), S.62(2)(c), S.63(2)(f);
MMPR S.117(1)(c) and
ACMPR S.43(1), S.46(1), S.184(d)
"The Minister shall refuse to issue an authorization to possess if any information, statement or other item included in the application is false or misleading;"

47. Witnesses from Nova Scotia testified in R. v. Godfrey [2014] to having been authorized with many others by Ontario's Dr. Kammermans upon his visit to Nova Scotia. On Oct. 1 2012, they received revocations of their exemptions for being false and misleading though no doubt about their medical condition was alleged. What may Health Canada have construed as "false?" Dr. Kammermans was not licensed to practice in Nova Scotia and had to sign the forms in his Ontario office!

48. Though one revokee never found another doctor, the other obtained another Authorization from a doctor in B.C. The Greenleaf Clinic does its medical examinations by Skype with the patient anywhere in Canada and the doctor in B.C. Similarly, had the doctor in B.C. done a house call to Nova Scotia and signed it there, Health Canada could have deemed that false and reject the application too. So Dr. Kammermans could have used Skype or waited until he was back in his Ontario office before signing and sending out the Authorizations to his Nova Scotia patients but because he signed them at the house call instead of in his office, Health Canada cut off the medication of thousands of valid patients for non-medical reasons as false!

6) NO EXEMPTION FROM CDSA S.5 TRAFFICKING

49. With different strains for different pains and different gains in productivity, Plaintiff's opportunity to sample and trade those strains is impeded by the trafficking prohibition in the CDSA. Without a DIN for financial support, it is evident that any PUPL patient on social assistance cannot divert his food budget to pay for his growing expenses and is compelled to traffic some of his

crop to cover those inevitable costs. The CDSA S.5 prohibitions on trafficking of marijuana are a clear impediment to the patient's benefit through access and supply of different strains.

7) NO DESIGNATED TRANSFORMERS

MMAR, MMPR, ACMPR fail to exempt transformers of marijuana to edibles and oils the prohibition on which was ruled unconstitutional in R. v. Smith [2015] by the Supreme Court.

50. In R. v. Smith [2015], the Supreme Court struck down the prohibition on cannabis transformed to joice, oil and edibles. Yet, transformers are still be charged for supplying that need. Without transformers, the right to oil and other products is unconstitutionally illusory.

8) STIFLE HEMP PRODUCTION

Industrial Hemp Regulations SOR/98-156 CDSA definition: "industrial hemp means the plants and plant parts of the genera Cannabis, the leaves and flowering heads of which do not contain more than 0.3% THC w/w."

**51. Wheat acreage in Canada is about 25,000,000 acres. Canola is about 20,000,000 acres. Hemp has averaged 25,000 acres under the impediment of Health Canada red-tape. Dealing with a prohibited plant causes inefficiencies that have kept hemp production a thousand-fold less than wheat. And though it has a seed yield comparable to other grains, it has a stalk that also is of untold uses. Yet, the most-useful plant of yore has been kept at minimum production that can only be attributable to Health Canada Regulations.
101. The most egregious such regulation is that hemp grown**

must contain less than 0.3% THC. With marijuana on the street containing 6-25% THC, making the threshold 20-fold less than necessary eliminates the use of any plants between 0.3% and 6% from being harvested for the tree, not the flower. The Canadian economy needs this most-beneficial source of biomass so badly that its suppression is causing detrimental effect on all the citizens of that economy.

UNDER THE MMAR AND ACMPR

9) TWO PATIENTS PER GROWER

MMAR S.41(b) prohibits producing under more than 1 registration. ACMPR: S.184 the Minister must refuse to register the applicant or to renew or amend the registration if (b) the person would become authorized to produce marihuana plants under more than two registrations.

52. Accused adopts the reasons from the Supreme Court of Canada decisions in Sfetkopoulos and Beren to submit that for Sfetkopoulos and Beren to completely strike down the cap on authorisations To Possess ("ATP") per gardener in MMAR S.41(b.1) for being unconstitutionally limiting and for the government to re-impose in MMAR S.32(e) a new limit of 2 ATPs per gardener makes the regime again contemptuously unconstitutionally deficient. While the cap was off, a gardener could grow for as many Exemptees as was most economical, perhaps 10 patients with 20 plants each rather than only one! When you have an indoor garden that could easily accommodate 200 plants, to be restricted to only 20 or 40 is a waste of expensive electrical resources. Lots of that light goes to waste. The government imposing a new cap of 2 where he could be more economically cultivating for 10

impedes supply as obviously as it did to the judges in Sfetkopoulos and Beren. The Crown gains nothing by keeping production inefficient and costly.

10) REGISTRATIONS PER SITE

MMAR 54 "if a production site is authorized under more than four licences to produce, the Minister shall revoke the excess licences."
ACMPR: S.184 the Minister must refuse to register the applicant or to renew or amend the registration if (c) the proposed site for the production of marihuana plants would be a production site under more than four registrations.

53. Applicant adopts the reasons from in R. v. Beren at the Supreme Court of Canada to submit that for Beren to completely strike down the 2-limit on both patients per gardeners and and 4-gardeners per garden in MMAR S.54(1) for being unconstitutionally limiting, and for the government to re-impose in MMAR S.32(d) a new limit of 4 gardeners per garden makes the regime again contemptuously unconstitutionally deficient. While the cap was off, gardeners could share one site as was most economical, perhaps a site with 10 gardeners rather than only 4. The government imposing a new cap of where 4 the 10 could be more economically cultivating together impedes supply as obviously as it did to the judges in Beren. Arguing that bumping the limit by 1 resolved the problem struck down by the courts seems contemptuous. Do the courts not sense being laughed at when they order unconstitutional limits struck down and the government responds with a new caps plus one? Especially when Crown Sean Gaudet in Sfetkopoulos admitted to the 2nd Bad Exemption No Offence period:

"Courts may construe the Federal Court of Appeal's decision as creating a similar period of retrospective invalidity dating back to December 3 2003, the date that s.41(b.1) was re-introduced into the MMAR." After the caps were struck and re-imposed plus 1, there is now a third similar Bad Exemption No Offence period? How would this court feel if it struck down the new cap of 4 and the government re-imposed new cap of 5?

54. The new caps of 2 replacing 1 and 4 replacing 3 make the MMAR and ACMPR only slightly less unconstitutional retrospective to Dec 8 2003 as their lesser versions in Hitzig had been retrospective back to Aug 1 2001 until the deficiencies were remedied on Oct 7 2003 in Hitzig.

11) NUMBER OF PLANTS INAPPROPRIATE PARAMETER

MMAR: S.30(2): "The maximum number of marihuana plants referred to in paragraph (1)(c) is determined according to..."
ACMPR S.190: "The maximum number of marihuana plants...

55. The limits on plants is inappropriate because different strains for different pains produce different gains of growth and only the stored amount should matter.

56. In R. v. Ray Turmel [2012] in Quebec, the accused had 4 pounds towards his Authorized 11 pounds but was charged with having too many plants, growing too fast. Such a limit impedes the patient's opportunity to fully stock his medicine chest by only him to reach his maximum storage very slowly. As well, different strains provide different yields making the number of plants the wrong main limiting factor that again impedes supply.

57. Limiting the number plants also means that gardening becomes a more expensive year-round chore. Instead of growing double for free in winter when no air conditioning is needed and taking the summer off, patients must tend to their gardens with no respite all year round.

12) NO HELP FOR GROWERS

58. A limited number of plants also means that they have to be grown bigger. Rather than small 10 gram buds on 20 small stalks, they have to grow 50 gram buds on 4 mini-trees. Bigger plants mean patients have to handle and get around bigger pots and reduces the efficiency of the lamp when light doesn't get through to the bottom buds. Having forced patients to deal with larger pots, the MMAR then prohibits them hiring or having any helpers which restricts access and supply! The ACMPR does now allow the patient to help the grower but no one else.

13) NO CRIMINAL RECORD FOR GROWERS

MMAR S.35(b), S.37(2d), S.39(1c) and ACMPR S.174(3)(a), S.176(2)(a), S.177(4)(a) make a Registered Person or Designated Person ineligible for a production license if they have been convicted of a "designated cannabis offence" within the preceding 10 years.

59. The Crown gains no benefit by banning people with experience in the industry when illegal from going straight now that it's legal. Such an imposition has no purpose but malevolence. Why ban the bikers from going straight for 10 years? It's irrational.

14) CALLS TO DOCTORS TO REDUCE DOSAGES

60. Under both regimes where personal production is not prohibited, Health Canada takes time to make intimidating phone calls to doctors trying to convince them to reduce their prescriptions with complaints to their associations to be passed along. No problem when buying from an L.P.

61. One doctor asked his patient to find another doctor after calls from Health Canada and his association! 200-400 grams per day may seem excessive but those who want juice without the psychoactive elements need lots of fresh leaves every day, not hundreds of grams of bud. But since no distinction is made, limiting people to 5 grams per day with deliveries of 150 grams negates their right under Smith to non-smokable juice.

15) DELAYS FROM NON-INSTANTANEOUS PROCESSING

62. Like any life-saving medication, marijuana should be available as fast as needed. Imagine an epileptic having a fit and a hospital emergency ward doctor trying to obtain an Authorization to use marijuana to stop it. That hospitals are not prepared to dispense marijuana to an epileptic in the throes of seizure is an indictment of the total regime. It's the only almost guaranteed anti-seizure medication not available at a hospital because of the application process for authorization. Hospitals remain as unprepared under the MMPR and ACMPR.

63. Applications to produce that took 4 weeks to process under the MMAR now take up to 30 weeks under the ACMPR all the while having to buy rather than grow their own medication and paying rent on the proposed site during the delay. It doesn't take much time to process so simple an application so it must be taking time to get to the top of the pile.

UNDER THE MMPR AND ACMPR

16) LP CANCEL REGISTRATIONS FOR REASONABLE SUSPICIONS

MMPR S.117(1)(c)(i): "The Licensed Producer must cancel if there are reasonable grounds to believe that false information has been submitted;"
ACMPR S.139(1)(c)(i): "must cancel without delay if LP has reasonable grounds to believe that the registration was made on the basis of false or misleading information.

64. Health Canada no longer cancels Exemptions for its own "reasonable grounds," it has delegated that onus onto the non-governmental Licensed Producer (LP). Action used to be taken if it "is false! Now it only needs "reasonable grounds to believe it is false." That bureaucrats or private companies and not the doctors rule the pharmacy by declaring non-medical errors or inconsistencies "false and misleading" is an indictment of the total regime. Health Canada bureaucrats can and did cut off the medication to thousands of Dr. Kammermans' medically-qualified patients for just such a trite non-medical reason.

65. What are "reasonable grounds to believe something false" for a private Licensed Producer to cut off a patient's medicine? Shouldn't it be upon "indictment or conviction" and not "reasonable grounds to believe?" "Oops, sorry for the mistake, patient's dead." If the Licensed Producer has verified grounds, he can call a cop, not say he has "reasonable grounds to believe." Or shouldn't it be up to the doctor to decide when medicine will no longer be given? L.P.s should call the police with reasonable grounds.

17) LP CANCEL FOR BUSINESS REASON

**MMPR S.117(4): "A licensed producer may cancel the registration of a client for a business reason."
ACMPR S.139(3) "for a "business reason;"**

66. "Business reason" to cut the patient's medicine is undefined in the legislation. But Health Canada has written:

> **"The term "Business" is generally defined as an enterprise or a firm which provides goods and services to its customers for a profit. Coming from that term "business reasons" could cover a wide spectrum of scenarios. For example, an organization could stop doing business with customers due to (the business decision based on) long-overdue, pending payments from the customer/client. Also, the licensed producer might close business, etc.**

67. Adding to the spectrum, "they're low on that brand and someone it profits more to sell it to someone else" is another great business reason.

68 Now that insurance companies are starting to cover payments to Licensed Producers, there is no reason for prices to come ever down for uninsured Canadians.

18) MEDICAL DOCUMENT NOT RETURNED BY LP

**S.117(7): "A licensed producer who cancels a client's registration must not return the medical document."
ACMPR S.139(7) A licensed producer who cancels a client's registration must not return the medical document to the cancelled patient.**

69. The Licensed Producer may cut off not only a patient's supply but also his access since he can't take his current "access document" to any other supplier and has to start the access process with the doctor all over again. If they close business, the patient should get his "medical document" back so he can take it to another who is still in business?

19) 150-GRAM LIMIT FRAUD

MMPR 20) S.5(c), S.73(1)(e), S.123(1)(e), S.130(2) and ACMPR S.6(1)(d), S.178(2)(f)(ii), S.189(1)(e) prohibit possession or delivery of more than 150 grams.

70. The 150-gram personal possession limit imposed on Exemptees under the "Medical Marijuana Access Regulations" ("MMAR") and the "Marijuana for Medical Purposes Regulations" ("MMPR") under-medicates by a factor of 9 based on fraudulent surveys by Health Canada thus inflicting on the group conditions of life calculated to bring about its physical destruction in violation of S.318(2) of the Criminal Code of Canada.

71. On Feb 7 2014, Health Canada's Jeanine Ritchot swore in an Affidavit for the Federal Court case No T-2030-13 of Allard v. HMTQ in paragraphs 24-29 with regard to MMPR S.5, S.130, S.122, S.123 "must not possess or deliver more than 30 x Daily dosage or 150 Grams":

> **24. 36,797 ATPs up to December 11 2013.**
> **25. 675,855 daily grams prescribed in 2013.**
> **26. Average licensed indoor plants 101, outdoor 11.**
> **27. Average daily amount 17.7g/day on Dec 12 2013.**
> **28. According to Ex. A "Information for Health Care Professionals" at page 24 "Various surveys published in peer-reviewed literature have suggested that the majority of people using smoked**

or orally-ingested cannabis for medical reasons reported using between 10-20 grams of cannabis per week or approximately 1-3 grams [Average of averages 1-3 = average 2] of cannabis per day."
29. Individuals who purchase their dried marijuana from Health Canada have on average purchased 1-3 grams per day, [Average of 1-3 = 2] which is in line with daily dosages set out in the most current scientific literature referenced "Information for Health Care Professionals" Ex.A"

72. 675,855/36,797 = 18.37g/d. I'll use 18g/d from now on. 101 plants average is based on average 20g/d prescribed, a factor of 5. After two emails from me requesting the cited surveys and peer-reviewed journals, Health Canada has not been able to provide that information.

73. The "Information for Health Care Professionals" states:

"Minimal therapeutic dose and dosing ranges
Various surveys published in the peer-reviewed literature have suggested that the majority of people using smoked or orally ingested cannabis for medical purposes reported using between 10 - 20 g of cannabis per week or approximately 1-3g [Average = 2g] of cannabis per day. Footnote 165, Footnote 277, Footnote 350.

74. There is something inherently wrong with speaking of a 1-3 gram average. The average of the averages is 2 grams. Averages are not stated as ranges. They are a point, an average. The fact we're given a two averages suggests improper or incompetent statistical analysis.

75. Footnote 165:

> **(1) Clark, A. J., Ware, M. A., Yazer, E., Murray, T. J. and others. (2004). Patterns of cannabis use among patients with multiple sclerosis. Neurology. 62: 2098-2100. The sample size was 144 was calculated to detect an estimated prevalence of 10% with a 2.5% standard error.**

76. Clark's study only discusses "single-dose size" and says not a word about daily dosage at all and results with the sample of only Muscular Dystrophy patients is hardly indicative of the average dosage for all other illnesses. 25% of the mean is a pretty big error due to the small n. Significance was set at the 95% level, that 2 Standard Deviations according to the Statistics Rule of 66-95-99.7: (1SD: 66% 2SD: 95% 3SD: 99.7%).

77. Footnote 277,

> **(2) Carter, G. T., Weydt, P., Kyashna-Tocha, M., and Abrams, D. I. (2004). Medicinal cannabis: rational guidelines for dosing. IDrugs. 7: 464-470: "In informal surveys from patients in Washington and California, the average reported consumption ranges between 10-20g raw cannabis per week or 1.42-2.86g/day..**

78. Carter's study has informal surveys for its guestimate, not peer-reviewed at all.

79. Carter continues:

> **Our recommended doses are further reinforced by two studies that utilized smoked cannabis in a well-documented dosing regime... (3) Chang and co-workers studied the effects of smoking 3.6 gram/day**

containing 15% THC... (4) Vinciguerra studied smoked cannabis dosed at 1.5 g/day.. These doses fall within the medical cannabis guidelines in the Canadian medical system.

80. Chang's study on 3.6g/day can't be found by Google but cannot tell us the average rams smoked by the general population. If everyone got 3.6 grams, that's the average they would sample. Neither can (4) Vinciguerra's study on the effect of 1.5g/day tell us the average smoked in the general population. If everyone got 1.5 grams, that's the average they would sample. So there's no way their "recommended doses are further reinforced by two studies that utilized smoked cannabis in a well-documented dosing regime." Fixed dosing regimes!!

81. Footnote 350.

(5) Ware, M. A., Adams, H., and Guy, G. W. (2005). The medicinal use of cannabis in the UK: results of a nationwide survey. Int.J.Clin.Pract. 59: 291-295.

82. Ware's survey gives no dosage average at all, and even if it did, over half the survey quit for lack of access or affordability! With more than half having a hard time getting it, an artificially-low average would be expected.

83. On Feb 7 2014, Health Canada's Todd Cain's affidavit in the Allard proceeding at paragraphs 30-31:

"30. Health Canada took significant steps to project demand and available supply for medical use. In anticipating demand, Health Canada took into account available information on numbers of individuals licensed to use dried marijuana for medical purposes, the upward trend in that number, the daily dosage amounts identified in the most

current scientific literature and international practice around dosage, as set out in the "Information for Health Care Professionals" available online at http://hc-sc.gc.ca/dhp-mps/marihuana/med/infoprof-eng.php

84. It was fraudulent for Health Canada to "rely on the daily dosage amounts identified in the most current scientific literature and international practice around dosage" and not rely on the actual daily dosage prescribed from the available information on numbers of individuals licensed to use dried marijuana for medical purposes and total production licensed.

85. Todd Cain continues:

> **31. The "Information for Health Care Professionals" document, at page iii states that "following the most recent update to this document (Feb 2013) a study was published in the Netherlands tracking data obtained from the Dutch medical cannabis program over the years 2003-2010. The study reported that in a population of over 5,000 Dutch patients using cannabis for medical purposes, the average daily dose of dried cannabis (various potencies) used was .68 grams per day (Range 0.65-0.82 grams per day) (Hazencamp and Heerdink 2013).**

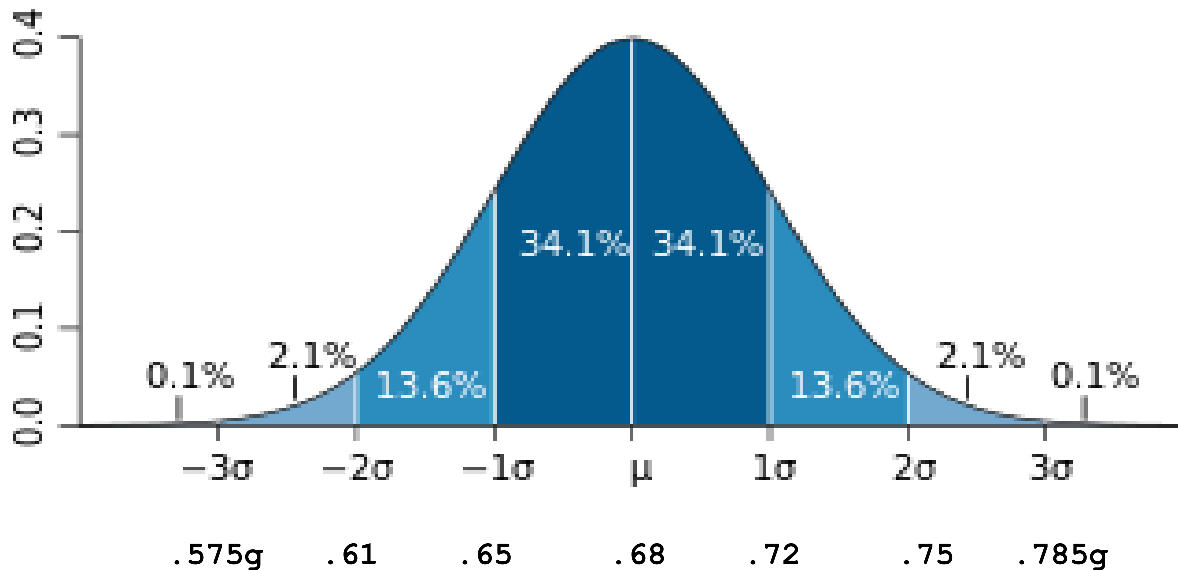
86. Google doesn't find the Hazencamp and Heerdink 2013 survey in the Netherlands with the only mention being in Todd Cain's Affidavit, certainly not yet in any published journal. He continues:

> **In addition, information from Israel's medical marijuana program (7) suggests that the average daily amount used by patients was approximately 1.5 grams of dried cannabis**

per day in 2011-2012 (Health Canada personal communication)"

87. A "personal communication" from Israel ("Hey Izzy, suggest a number!") is not a survey in a peer-reviewed journal on Israel's medical marijuana program suggesting the average daily amount used by patients was approximately 1.5 grams/day in 2011-2012.

88. Of the studies cited at Health Canada's "Information for Health Care Professionals" page (1) Clark discusses single doses; (2) Carter has "informal surveys" citing (3) Chang who studies fixed 3.6g/day, not different daily dosages, and (4) Vinciguerra who studies fixed 1.5g/d, again, not different daily dosage; (5) Ware doesn't mention daily dosage at all; (6) Hazencamp isn't found; (7) Izzy's suggestion shouldn't count.

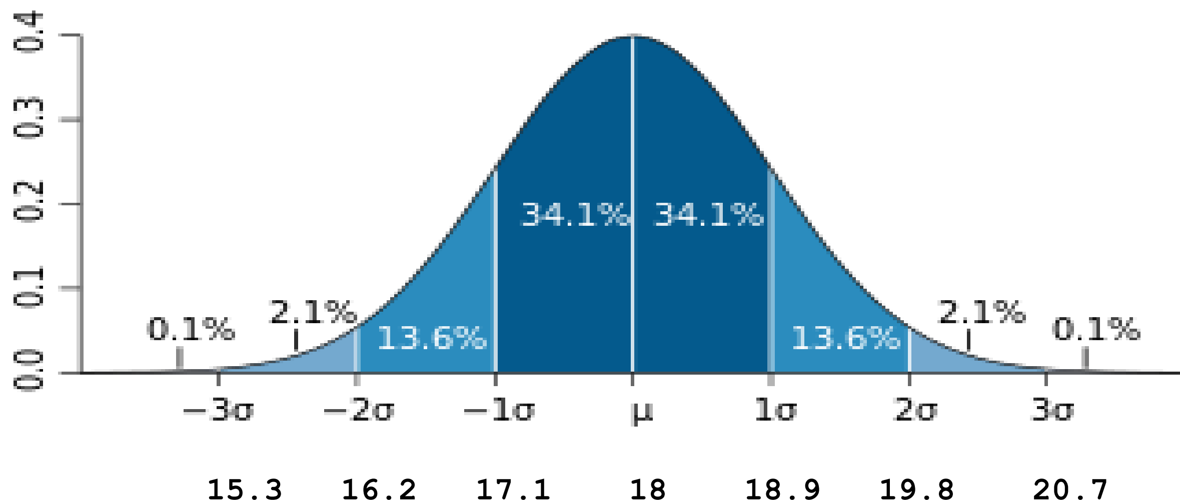


89. Presuming the Hazencamp survey of 5,000 patients may exist, it stated the Standard Deviation Error for their Bell Curve range around their average of 0.68 was .065-0.72. Under the Bell Curve, half the results reported more and half reported less than 0.68g/d. Bell Curve #1 shows that 3,333/5,000 results (66%) fell between 0.65-0.72; and 4,750/5,000 results (95%) fell between 0.61-0.75.

4,985/5,000 (99.7%) fall within 0.575-0.785, and 4,999.7/5,000 (99.997%) fell within 0.54-0.82. It's 33,000:1 against a result exceeding 0.82g. It's millions to one against 0.9g/d. Billions to one against hitting 1g/d in that study.

90. Yet, Health cited the informal Israeli "survey" suggesting an average of 1.5g/d. For the Dutch 0.68 average survey to find one 1.5g/day is (1.50-0.68))/.034 = 24 Standard Deviations off possible. Didn't someone notice the two polls contradicted each other? Reputable polls cannot have one poll with double the average of the other with such small standard deviations. It is completely improbable that both surveys could be honest random samplings of the general population consumption with the same parameters sought to define the 150g limit.

91. The actual Canadian mean of 18 is (18.0-.68)/.034 = 500 Standard Deviations from their Netherlands survey average!!! It cannot be an accurate representation of Canadian demand upon which to base the 150 gram limit! It would be a miracle that one, let alone the average of Canada's 40,000 users, should be so off the 0.68g/d average cited in the Netherlands survey.



92. Bell Curve #2 shows the actual known mean of 18 and presuming the same spread of 5% either side of the mean, that's 17.1-18.9g for 1SD, 16.2-19.8 for 2SD, 15.3-20.7 for 3SD and 14.4-21.6 for 4SD. For any surveys sampling a Canadian population with known mean of 18g to claim results with Bell Curves around averages of 3g [(18-3)/0.9 = 17SD] or 1g [(18-1)/0.9 = 19SD] cannot be taken as valid or honest. The fix was in. There were different parameters used.

93. So actually, not one of the studies cited in Health Canada testimony backs up the proposition that the proper estimated daily average of averages is 2 grams per day in the face of actual admitted evidence that it is 18 grams per day when self-produced. Not one article in any peer-reviewed journal suggesting daily dosage of 1-3g/d [Average = 2g] to validate the 5g/d, hence 150g per month, limit of 150 grams in the new MMPR.

94. Justice Manson was not alerted to the fraudulent evidence before his court and ruled at Para.55:

> **As of Dec 3, 2013, the average daily dosage is 17.7 grams per day. Despite this, the average amount used by those being supplied by Health Canada was between 1 and 3 grams.**
> **"iii. Speculation about the Effect of Limits on Personal Production**
> **[86] The Respondent also argues that the Applicants' concerns regarding the limits on personal possession under the MMPR are unfounded. The new limit of 150 grams limit was based on an average use of 1-3 grams [Average of 1-3 = 2] per day of medicinal marihuana by those being supplied by Health Canada and reflects appropriate dosage amounts identified in scientific literature.**
> **[87] As stated above, the harm alleged must not be hypothetical or speculative. It cannot be comprised of**

generalized assertions, unsupported by evidence and it must be real and substantial. However, harm that will occur in the future does not necessarily mean the harm is speculative. Instead, it is "...the likelihood of harm, not its futurity, which is the touchstone" (Horii v Canada, [1991] FCJ No 984 at para 13).

[88] Paragraph 59 in RJR-MacDonald also alludes to a wrinkle in interlocutory injunctions in the context of this motion. The ability to compensate in damages, a traditional measure of what constitutes reparable harm, is complicated in constitutional cases, as damages are presumptively unavailable against the government for enacting unconstitutional legislation in the absence of bad faith or an abuse of power (Mackin at paras 78-80). I consider the Applicants' citation of RJR-Macdonald at para 61 to be apt: "...it is appropriate to assume that the financial damage which will be suffered by an applicant following a refusal of relief, even though capable of quantification, constitutes irreparable harm.

[89] Turning to the evidence, I agree with the Respondent that there is inadequate evidence to show that there will be an insufficient supply of marihuana under the MMPR. Mr. Cain details in his affidavit the steps that Health Canada has taken to forecast consumer demand and the various contingencies put in place to deal with a shortfall, including stockpiling marihuana and arranging for imports, if necessary. The Applicants' argument with regard to supply amount to nothing more than speculative assertions.

[91] The Applicants also have failed to prove that the 150 gram personal possession limit imposed by the MMPR would constitute irreparable harm.

95. Justice Manson based his ruling on Health Canada's perjured testimony. His 150g monthly limit derived from Health Canada's average 2g/d survey samples is actually 9 times too low! Given the true population mean is 17.7, not 2g, a month's supply for the average patient would be 540g rather than 60g (30g-90g)! And given Health Canada's 2.5 safety factor for those dosages above average, that would be not 150 grams maximum possession limit per delivery but 1,350 grams shippable!! Health Canada offers supply 9 times too slow supply, an underestimate of 89%!

96. As well, none of the Allard Plaintiff's are large users while Michael Pearce's latest prescription was Canada's highest: 260g/day. How could Justice Manson have explained a 150-gram limit to those with prescriptions greater than 150 grams per day if they had been there?

97. Justice Manson noted in Para.55 that despite a daily average of 17.7g/d total prescription, Health Canada's retail sales were 1-3g/d [Average = 2g/d]. To impose on the group a new limit based not on actual total volume prescribed but on retail sales with the home-grown production excluded was a serious mis-under-estimate of true demand.

98. Given Health Canada has no peer-reviewed surveys upon which to base their regularly-cited 2g/d average of averages when objective data was always available of the average being 18g/d, it is submitted that the 150 gram limit on the amount of cannabis possessed and shipped has been set 9 times too low based on false and misleading testimony and evidence.

99. The 150-gram limit makes the option of bulk discount buying impossible, always only retail prices.

GENOCIDAL EFFECT

100. Health Canada's fraudulently under-estimate of the average cannabis dosage required by MMAR and MMPR patients misled Manson J. to "inflict on the group conditions of life calculated (89%) to bring about its physical destruction" as of April 1 2014. Failure to permit affordable self-production does the same. The Criminal code states:

> **Definition of "genocide"**
>
> **318. (2) In this section, "genocide" means any of the following acts committed with intent to destroy in whole or in part any identifiable group, namely,**
>
> **(b) deliberately inflicting on the group conditions of life calculated to bring about its physical destruction**

101. Health Canada's fraudulently under-estimate of the average cannabis dosage required by MMAR and MMPR patients misled Manson J. to "inflict on the group conditions of life calculated (89%) to bring about its physical destruction" as of April 1 2014. Failure to permit affordable self-production does the same.

20) L.P.S CANNOT SUPPLY FRESH LEAVES, JUICE, OIL

102. In R. v. Smith [2015], the Supreme Court ruled prohibition on all non-dried forms of marijuana violated the Charter. Though eating the leaves, drinking the juice and applying the oil are now legal, fresh leaves, fresh juice and oil remain unavailable though the Licensed Producers. The preponderance of many underground dispensaries shows the lack of supply but no one supplies fresh leaves or juice yet.

21) UNAFFORDABILITY

103. The Canada Health Act R.S.C., 1985, c. C-6 states:

> **"3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."**

104. Doctors don't fill out forms for free. Making permanently ill patients have their doctor fill out a form every year is an unconscionable waste of everyone's time and resources.

105. Despite no DIN, patients finds it affordable to produce the required cannabis at $1.00 to $4.00 a gram or less but are not able to afford the estimated Licensed Producer prices which are comparable to illicit market prices and that unaffordability is a barrier to access at Plaintiff's income level.

106. The Allard rulings both cite accessibility as a function of affordability.

107. The 150-gram limit makes discount bulk buying impossible to maximize the cost of this unsubsidized medication.

PART IV – ORDER SOUGHT

108. Applicant seeks an Order declaring:

A) the MMAR-MMPR-ACMPR marijuana medical exemption regimes invalid for violating the accused's S.7 Charter right.

B) Controlled Drugs & Substances Act:

S.4, S.5, S.7 prohibitions on marijuana of no force and effect while the exemption is unconstitutional pursuant to R. v. Parker (2000) and R. v. Krieger (2000);

109. Accused further seeks an Order:

C) staying the charges against the accused, and if jurisdiction:

D) striking the word "marijuana" from CDSA Schedule II;

E) expunging all convictions registered since Aug 1 2001;

F) returning the seized Controlled Substance be returned to Applicant pursuant to S.24 of the CDSA.

Dated at ________________________ on _________ 201__.

____

Applicant/Accused Signature

Name: ____________________________________

Address: _________________________________

Tel/fax? _________________________________

Email: ___________________________________

CC: Federal and Provincial Attorneys-General

HER MAJESTY THE QUEEN **V.** ______________________

Plaintiff **Accused**

File No: _________

_________ **COURT OF JUSTICE**

(Criminal Division)

Between:

____

Applicant/Accused

and

Her Majesty the Queen

Respondent/Plaintiff

AFFIDAVIT OF SERVICE
(used only if Crown won't accept service)

On ________ 20___, I, ____________________, did personally serve a true copy of this document on the office of the Crown

Attorney at _____________________________

____
Affiant's Signature

Sworn before me on ____________, 20___

____
A COMMISSIONER, ETC

RECORD OF APPLICATION

AND CONSTITUTIONAL ISSUE

For the Applicant/Accused:

Address:_____________________

____

Tel/fax: ________________________

Email: ________________________

INSTRUCTIONS

This is the latest Charter Motion to declare the ACMPR and CDSA prohibitions invalid.

Everything is in the right order already. Drop instructions. Sign and date everything. Covers called "RECORD" in blue paper, first and last pages.

Serve your prosecutor before filing with court. If the Crown won't sign receipt on the back page, hand him a motion anyway and then go to a Justice of the Peace and fill out the Affidavit of Service on the back of the motion, swear it and now you can file it.

johnturmel@yahoo.com
http://johnturmel.com/medpot for how to serve.

You must serve one on each Crown, federal and provincial. If you cannot ascertain a date, you put "the date of trial" to fill in the blank.

Notice of Constitutional Question must be faxed to the Provincial Attorney General numbers on the document 30 days before the hearing of the motion. Takes half an hour. Instructions on the http://johnturmel.com/kits page