



Delaware Medical Marijuana Complaint Form

Your Information

Please provide all the information you may have to assist in the investigation of this complaint

Last Name: _____
First Name: _____
Address: _____
City, State, Zip: _____
Daytime Phone: _____
Best time to contact you: _____
Email Address: _____

Establishment/Facility Complaint is Against

Facility Name: _____
Facility Address: _____

Complaint Information

Please provide details of the complaint, use page #2 if necessary

Date of Incident: _____
Type of Incident: _____
Are there others who can corroborate the incident? Yes No
If yes, please provide contact information: _____

Details of
Complaint: _____

Submit this form electronically or print and forward with any additional documentation to:
Medical Marijuana Program: 417 Federal St., Dover, DE 19901
Email with any attachments to MedicalMarijuanaDPH@state.de.us or click on the submit button below

Submit via email

