Ohio | Department of Commerce

OHIO MEDICAL MARIJUANA CONTROL PROGRAM
INCIDENT REPORT FORM

LICENSEE NAME:	**LICENSE NUMBER:**
LICENSEE ADDRESS:	
LICENSE TYPE: ☐ Cultivator Level I ☐Cultivator Level II ☐ Processor ☐ Testing Laboratory	
LICENSEE CONTACT PERSON/TELEPHONE NUMBER:	
DATE/TIME OF INCIDENT:	**Location of incident** *(Example: Flower Room, Vault):*
NATURE OF INCIDENT *(Example: Camera outage, equipment failure, security breech, etc. Provide details.):*	
ISSUE RESOLVED? (YES/NO): ☐ Yes ☐ No	**DATE/TIME OF RESOLUTION:**
ISSUE RESOLUTION:	
OUTSIDE AGENCY CONTACTED? (YES/NO): ☐ Yes ☐ No	**CONTACT AGENCY NAME/TELEPHONE NUMBER:**