MEDICAL CANNABIS DISPENSARY VIDEO SURVEILLANCE SYSTEM OUTAGE REPORTING FORM: PLEASE PROVIDE THE FOLLOWING TO DOCUMENT ANY SYSTEM FAILURES.

Dispensary Name:___________________________________________________________________
Registration Number:________________________________________________________________
Date and time of Division notification:__________________________________________________
Primary Agent in Charge: ____________________________________________________________
Agent completing this form:___________________________________________________________
Brand of surveillance system at dispensary:_______________________________________________
Name of surveillance system vendor:___________________________________________________
Name and phone number of vendor who maintains network:_________________________________
Name of IT services/server vendor:_____________________________________________________
Date and Time outage discovered:______________________________________________________
Date & time issue was resolved:________________________________________________________
Agent who discovered outage:_________________________________________________________
Was surveillance vendor contacted?_____________________________________________________
If vendor contacted indicate when:______________________________________________________
Did failure notifications alert staff? _____________________________________________________
If Camera outage: 
Indicate which cameras were involved:__________________________________________________________________________________________

For video recording outage:
What does the furthest back date the system can view recordings? __________________________
Please attach a time stamped photo indicating furthest back system has stored recordings.
If less than 90 days, please explain in detail the reason:____________________________________
________________________________________________________________________________________
Approximate date dispensary expects to be back in compliance:______________________________
Did the dispensary close temporarily due to the outage? _____________________________________
If yes, indicate dates and times of closure:
Begin date & time ________________________ End date & time ______________________________
Please specify the precise time periods of any gaps in recordings:
Beginning date & time______________________ ending date & time__________________________
Beginning date & time______________________ ending date & time__________________________

Please describe steps dispensary can take to prevent this issue from happening again
________________________________________________________________________________________
________________________________________________________________________________________

Please attach the dispensary’s last two 30-day security system checks and any repair invoices from video surveillance vendor.

Please send a time stamped photo by email to the Division of how far back recordings can be viewed every 30 days until back in compliance with the requirement for storing 90 days of recordings.

Signed _______________________________________ Date ____/_____/_______