NEW MEXICO DEPARTMENT OF HEALTH

Medical Cannabis Program

Website: www.nmhealth.org/go/mcp **Telephone Number**: 505-827-2321

There is no charge to apply for a Primary Caregiver ID card.

An application that is not complete or hard to read may delay your card. Send only ORIGINAL pages of the application. The program cannot accept photocopies, faxes or electronic copies. Send everything that is needed together in one packet.

Please keep a copy of everything you send in, including a copy of your New Mexico ID and background check documents.

Please send renewal applications at least 30 days before your card expires. Renewal applications can be sent up to 90 days before your card expires. Your card will expire every three years.

Every year between renewals, you and the patient will need to send an Annual Certification Form completed by you, the patient, and the patient's medical provider to remain enrolled in the Medical Cannabis Program. Please send this before the date printed on your card.

Checklist and Instructions for Primary Caregiver Applications

This application is for the Primary Caregivers of new and current patients.
Please use the checklist to be sure you have everything you need for your application.

- ☐ Completed "Patient Application" for the patient who needs a Primary Caregiver (unless the person is already a patient).
- ☐ Completed NATIONWIDE background check through an online company.
  - *PLEASE NOTE*: Have the documents sent to you and send them with your application.
- ☐ Completed "Primary Caregiver and Patient Information Form" (Page 1).
  - Make sure your form is complete and all the information is correct.
  - *NOTE*: Your mailing address is where you want your card sent.
- ☐ Completed "Medical Certification Form for Primary Caregivers" (Page 2).
  - This is filled out by the patient's medical provider.
- ☐ For those under the age of 18, a clear copy of the patient's birth certificate and a completed "Parental Consent Form for Minors" (Page 3).
- ☐ Both you and the patient need to sign and date the form. These must be *ORIGINAL* signatures.
  - If the patient is 18 years old or older and the form is signed by someone else, send legal papers that allow this (e.g.: Medical Power of Attorney or guardianship papers).
  - If the patient is under 18 years old and the form is signed by a parent or guardian, please include a copy of the patient's birth certificate or guardianship papers.
- ☐ Clear copy of caregiver's valid New Mexico Driver's License or New Mexico photo ID.
  - Temporary New Mexico Driver's License and photo IDs are acceptable.

Once complete, please mail or drop off your application to the Medical Cannabis Program:

Mail To: Department of Health
Medical Cannabis Program
1190 S St. Francis Dr., PO Box 26110
Santa Fe, NM 87502-6110

Drop Off To: Department of Health
Medical Cannabis Program
1474 Rodeo Road, Suite 200
Santa Fe, NM 87505

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Primary Caregiver Information

Individuals convicted of a felony violation for trafficking of controlled substances (*NMSA Section 30-31-20*), distribution of a controlled substance to a minor (*NMSA Section 30-31-21*), or the prohibited distribution of a controlled or counterfeit substance (*NMSA Section 30-31-22*), or a violation of any equivalent statute in another state or country, cannot serve as a PrimaryCaregiver.

First Name: _____ **Last Name**: _____

Middle Name: _____ Date of Birth (MM/DD/YYYY): _____

Phone Number: _____ Email: _____

Mailing Address: _____

City: _____

Zip Code: _____

New Mexico County of Residence: _____

I (the Primary Caregiver) agree that all the information is complete and correct. I agree to take responsibility for managing the well-being of the qualified patient named in this application with respect to their medical use of cannabis. I will follow the rights and restrictions to serve as a Primary Caregiver to a Medical Cannabis Patient that are in the laws of New Mexico*.

_____ _____

(Primary Caregiver Signature) (Please print form - then sign) (Date)

Patient Information

First Name: _____ **Last Name**: _____

Middle Name: _____ Date of Birth (MM/DD/YYYY): _____

Phone Number: _____ Email: _____

Mailing Address: _____

City: _____

Zip Code: _____

New Mexico County of Residence: _____

I (the Patient) agree that all the information is complete and correct. I agree that this application is necessary to help manage my well-being while using medical cannabis according to the laws of New Mexico*.

_____ _____

(Patient Signature**) (Please print form - then sign) (Date)

* The Lynn and Erin Compassionate Use Act and the NM Administrative Code 7.34.3 can be found at nmhealth.org/go/mcp.

** If signed by someone other than the applicant, send legal documents to show this is allowed by law (may be a Medical Power of Attorney or Guardianship papers).

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Primary Caregiver Medical Certification Form

TO BE COMPLETED BY A MEDICAL PROVIDER

Patient's Full Name:_____ Date of Birth (MM/DD/YYYY): _____

Provider Name:_____ Clinical Licensure (MD, DO, NP, PA, etc.): _____

Board Certified Specialty:_____ NM Medical License #: _____

DEA License #:_____ NM Controlled Substance License #: _____

Office Mailing Address:_____ City:_____ State: NM Zip: _____

Provider Telephone Number:_____ Provider Fax Number: _____

Patient's Qualifying Condition: _____

If performed via telemedicine, provide the date of the patient's in-person evaluation (required): _____

Medical justification for the patient's need for a Primary Caregiver: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

By signing below, you are certifying that the patient needs assistance managing their well-being and that the person applying to be the patient's Primary Caregiver is capable of assisting the patient with acquisition and administration of medical cannabis in accordance with the laws of New Mexico (The Lynn and Erin Compassionate Use Act and the NM Administrative Code 7.34.3. These laws are on the program's website at: nmhealth.org/go/mcp).

Medical Provider Signature:_____ Date: _____

(Please print form - then sign) (Must be dated within 90 days of program receipt)

Be sure to include the **Caregiver's NM State ID and national background check.**

Once complete, please mail or drop off your application to the Medical Cannabis Program:

Mail To:
Department of Health
Medical Cannabis Program
1190 S St. Francis Dr., PO Box 26110
Santa Fe, NM 87502-6110

Drop Off To:
Department of Health
Medical Cannabis Program
1474 Rodeo Road, Suite 200
Santa Fe, NM 87505

NMDOH USE

Program Staff Signature:_____ Date: _____

☐ Approved ☐ Denied ☐ Additional notes in BioTrack

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Parental Consent Form for Minors

ONLY REQUIRED FOR APPLICANTS UNDER 18 YEARS OF AGE

I,_____, following New Mexico State Law (the Lynn & Erin
(Print Parent or Guardian's Name)

Compassionate Use Act and the NM Administrative Code 7.34.3), certify the following:

- I am the Parent (or Legal Guardian) of _____.
  (Print Minor's Name)
- The minor's medical provider has explained the potential risks and benefits of the use of medical cannabis to the minor and to me as the parent or legal representative of the minor.
- If approved, I consent to the minor's use of medical cannabis.
- If approved, I agree to serve as the minor's Primary Caregiver.
- If approved, I agree to control the acquisition, dosage, and frequency of the medical cannabis used by the qualified minor.

Parent's First Name:_____ Parent's Last Name: _____

Parent's Date of Birth (MM/DD/YYYY):_____ Phone Number: _____

Mailing Address:_____ City: _____

County:_____ Zip: _____

_____ _____

Parent or Guardian's Signature Date

(Please print form - then sign)