

Application Checklist

New Mexico



Please print clearly - Forms will be returned to the patient without further processing if any portion is left blank. Incomplete applications will be kept on file for six months from the date received by the program; after six months it will be voided and a new application must be submitted.

Faxed and electronic copies will not be accepted.



For Patient Applications:

This checklist applies to both new enrollments and re-enrollments.

Please keep a copy of all application documents for your records. The program is not able to make copies for you, this includes your NM ID

Please do not send us original medical records; we will not be able to mail them back to you.

- Information Form filled out completely
- Medical Certification Form filled out completely
 - Chronic Pain, a separate board certified specialist certification is required.
 - PTSD, medical records showing a *psychiatrist's* diagnosis
 - Glaucoma, medical records showing an ophthalmologist's diagnosis
 - Inflammatory Autoimmune-Mediated Arthritis, you must have a certification from a Rheumatologist.
 - Hepatitis C Infection, currently receiving antiviral treatment proof of current anti-viral treatment required
 - Painful Peripheral Neuropathy, submit medical records with diagnosis
- Release of Medical Information Form filled out completely
- Valid NM issued Photo ID or Driver's License. – PLEASE MAKE SURE IT IS CLEAR AND VISIBLE. (Temporary IDs are not accepted)
- If you wish to produce your own medical cannabis, a completed application for a Patient Personal Production License (this must be completed annually or if any information changes i.e. location, security etc.)

Send Application to:

Medical Cannabis Program
New Mexico Department of Health
1190 St. Francis Drive S-1300
Santa Fe, NM 87502-6110

Contact Information

Email: medical.cannabis@state.nm.us
Website:
http://www.nmhealth.org/IDB/medical_cannabis.shtml

Enrollment/Re-enrollment Information Form

New Mexico



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Medical Cannabis Program

New Patient Re-enrolling Patient (Patient ID # _____)

(Name must match the name on NM ID)

Applicant First Name: _____ Last: _____ Middle: _____

Mailing Address: _____

City: _____ County: _____ Zip Code: _____

Phone Number: _____

Email: _____

The address provided below must be your physical residence and will appear on your patient card. (Subject to approval)

Physical Address: _____

City: _____ County: _____ Zip Code: _____

Date of Birth: _____

Patient Signature: _____ Date: _____

A CLEAR COPY OF A VALID NEW MEXICO PHOTO ID OR DRIVER'S LICENSE MUST BE PROVIDED. PLEASE EITHER COPY IT IN THE SPACE BELOW OR PROVIDE IT ON A SEPARATE PAGE (Temporary IDs will not be accepted)

New Mexico Photo ID or Driver's License

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Chart Created: _____

Enrollment/Re-enrollment Medical Certification Form

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Medical Cannabis Program

THIS FORM MUST BE COMPLETED IN FULL BY THE MEDICAL PROVIDER

Attention Physicians and Patients: Any Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, or Physician's Assistant who can independently prescribe and administer controlled substances in New Mexico is legally able to write a certification for medical cannabis.

Applicant First Name: _____ **Last:** _____ **Middle:** _____

Patient Date of Birth: (for verification in case of duplicate names) _____ / _____ / _____ (MM/DD/YYYY)

Medical Reason for Provider Certification

Please check only one condition (checking multiple conditions may delay the application process)

- Amyotrophic Lateral Sclerosis
- Cancer (please specify type) _____
- Crohn's Disease
- Epilepsy
- HIV/AIDS
- Hospice Care
- Intractable Nausea/Vomiting
- Multiple Sclerosis
- Severe Anorexia/Cachexia
- Spinal Cord Damage with Intractable Spasticity

These conditions have additional requirements for submission.

- Glaucoma** (Ophthalmologist diagnosis required)
- Hepatitis C Infection currently receiving antiviral treatment** (proof of current anti-viral treatment required)
- Inflammatory autoimmune-mediated arthritis** (Rheumatologist certification required)
- Painful Peripheral Neuropathy** (submit medical records with diagnosis)
- Severe Chronic Pain** (this condition must be accompanied by two medical certifications, one from a primary care provider and a **second** from a **specialist with expertise in pain management or expertise in the process that is causing the pain.** This applies to both new applications and re-enrollments).
- Post-Traumatic Stress Disorder** (signed documentation providing proof of the diagnosis by a **psychiatrist or psychiatric nurse practitioner** must be included with this certification. VA disability statements are not sufficient. Diagnostic notes, clinic notes or a signed statement are required.)

Written certification MUST be provided below pursuant to the *Lynn & Erin Compassionate Use Act of 2007*, certifying 1) the aforementioned patient has a debilitating medical condition and the potential health benefits of the medical use of marijuana would likely outweigh health risks for the patient. 2) the aforementioned patient has current unrelieved symptoms that have failed other medical therapies: (Attach a separate page if more space is needed)

In addition to the written certification provided above, the provider must complete this section for re-enrollment applications: Provider must re-certify that the patient's medical condition still warrants the use of medical cannabis. Please mark the answer that applies.

- Yes No --Are there any changes in the patient's circumstances that would affect his/her eligibility status? _____ Provider's Initials
- Yes No --Do you believe this person still meets the eligibility requirements for the Medical Cannabis Program? _____ Provider's Initials

The New Mexico Department of Health, Medical Cannabis Program will verify the information provided within 30 days of receiving a full and complete application. Verification of medical information may include, with patient consent, examination of medical records documenting the patient has a current diagnosis of a debilitating medical condition. Certification must be provided by a practitioner as defined in Section 3 of the *Lynn & Erin Compassionate Use Act of 2007*, "a person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act."

Provider Name: _____ **Length of time patient in care:** _____

Provider Clinical Licensure (MD, DO, NP, PA, etc.): _____ **Board Certified Specialty:** _____

Provider Address: _____

City: _____ **County:** _____ **State** NM **Zip Code:** _____

Provider Telephone Number: _____ **Second Telephone Number:** _____

NM Medical License #: _____ **DEA License #:** _____

NM Controlled Substance License #: _____

Medical Provider Signature: _____ **Date:** _____

By signing above you are certifying patient eligibility for enrollment in the New Mexico Department of Health Medical Cannabis Program and agreeing to have patient medical records audited as necessary.

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Chart Created: _____

Approved Not Approved

Medical Director Signature: _____ Date: _____

Program Coordinator/Manager Signature: _____ Date: _____

Release of Medical Information Form

New Mexico



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Medical Cannabis Program

I, _____ hereby authorize the New Mexico Department of
(Please Print Name)

Health Medical Cannabis Program to discuss my medical condition, including treatment records, test results, and evaluations specific to _____ with my
(Please Print Qualifying Medical Cannabis Condition)

Certifying Medical Provider

First Name: _____ Last Name: _____
(Please Print Certifying Medical Provider's Name)

and if applying under Severe Chronic Pain, my board certified Specialist

First Name: _____ Last Name: _____
(Please Print Specialist's Name)

I understand that I may revoke this release at any time. I also understand that if I wish to revoke this authorization, I must do so in writing to the Medical Cannabis Program Coordinator, and that revocation may result in the inability of the program to certify me as a Medical Cannabis Program participant. Additionally, I understand that the revocation will not apply to information that has already been released in response to this authorization. The information disclosed pursuant to the authorization is subject to potential re-disclosure by the recipient, and will not be protected by the HIPAA privacy rule. I understand that this disclosure is voluntary and that signing this form is not necessary in order to receive treatment from DOH. This release is required, however, to verify my eligibility for the Medical Cannabis Program.

By signing this release I certify that I am aware that the program may provide verification of my enrollment and personal production license status with law enforcement; but only for the purpose of verifying that a person is lawfully enrolled in the medical cannabis program, or in the event that the medical cannabis program manager or designee has reason to believe that a qualified patient or patient-applicant may have violated an applicable law.

This authorization will expire in one (1) year unless a different expiration date prior to one year is specified here: ___/___/___

Participant Signature or Personal Representative: _____

Print Name: _____

Date: _____

If this form is signed by a personal representative, a witness must sign below:

Witness Signature _____

Date: _____

Mailing Address:

1190 St. Francis Drive, Suite S-1300

P.O. Box 26110

Santa Fe, NM 87502

Email: medical.cannabis@state.nm.us

Website: www.nmhealth.org/idb/medical_cannabis.shtml



Personal Production License Application

Please print clearly - This form **will not be processed** if any portion is left blank. Incomplete applications will be kept on file for six months from the date received by the program; after six months it will be voided and a new application must be submitted.

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Medical Cannabis Program

Medical Cannabis can only be grown on the qualified registered patient's property or residence.

Please note for annual renewal of the Patient production licenses (PPL). The PPL expires the same date your patient enrollment in the medical cannabis program expires. In order to renew your PPL, you must submit this form with any applicable fee 30 days prior to the expiration date, or it may expire. If your license expires, you may still submit a new application for a personal production license. **Please be aware that if your license expires, you will lose any legal protection to produce medical cannabis for personal use until you receive your new license. It is illegal to produce medical cannabis without a PPL in the State of New Mexico. So, please make sure you submit your renewal**

Please remember, this form must be complete and legible.

Applicant Information: The information provided, with the exception of telephone number and date of birth, will be printed on your personal production license.

Name: _____ Date of Birth: _____ Telephone Number: _____

Medical Cannabis Registry I.D. # _____ (if already approved for the program)

Physical Address: _____

City, State zip code: _____

Mailing Address: _____

City, State zip code: _____

Please provide detailed and complete answers for the following questions. These questions are to help ensure not only the safety of your production of medical cannabis, but your personal safety as well!

Any questions left incomplete may delay or stop the processing of your PPL application.

- Provide a description of the overall location where the medical cannabis will be produced.
 - Include a description of the area around the facility (i.e. is it a business area, industrial area, heavily populated, rural, neighborhood housing, apartment complex, etc):

- Describe* the building and room(s) (or outdoor location) where the medical cannabis will be produced.

- Provide a detailed written plan **ensuring the cannabis production will not be visible** from the street or any other public areas (you may include maps or pictures on a separate sheet, but you must have a written plan):

Continued on next page



Personal Production License Application



Medical Cannabis Program

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3. Describe what device(s) will be used to ensure security of the production and storage areas, and for your personal safety (lack of appropriate security is a reason for denial of license):

4. A patient living in a household of one and earning less than 200% of the Federal Poverty Guidelines, is not subject to a personal production license fee (for example, a household of one earning less than \$1815 per month is below 200% of the Federal Poverty Guidelines). Qualified patients who live in a household of one that earn more than 200% of the Federal Poverty Guidelines must pay a non-refundable fee of \$30.00 to receive a license to produce medical cannabis. **If you are above 200% of the Federal Poverty Guidelines**, please include a check or money order for \$30.00 payable to the New Mexico Department of Health Medical Cannabis Program with your application. These guidelines can be found online at <http://aspe.hhs.gov/poverty/index.shtml#latest>.

My household makes **less** than 200% of the Federal Poverty Guidelines (no fee). *Proof of income must be submitted in the form of the most recent year's tax return (not the last year you filed). If you are unable to submit the most recent year's tax return, the \$30 non-refundable fee must be included. No exceptions for this requirement will be accepted.*

My household makes **more** than 200% of the Federal Poverty Guidelines **and** a \$30 non-refundable check or money order is included. *Please note: if you are paying the fee, there is no need to submit proof of income!*

_____ Please write the check # or money order # for additional proof of payment here.

By signing below I certify that all the information submitted above is complete and correct. I also acknowledge that I have read and will abide by the limitations and restrictions on my right to use, possess, and produce medical cannabis as stated in the Lynn and Erin Compassionate Use Act and in New Mexico Administrative Code 7.34.4, the full text can be found on the program website listed below. This limits me to four (4) mature plants (flowering) and twelve (12) immature seedlings (non-flowering) and an adequate supply for personal use.

Applicant Signature: _____

Date: _____

All applications should be sent to:
Medical Cannabis Program
Infectious Disease Bureau
New Mexico Department of Health
1190 St. Francis, Drive, S-1300
Santa Fe, NM 87502

Contact the Medical Cannabis Program at:
Email: medical.cannabis@state.nm.us
Website: http://www.nmhealth.org/idb/medical_cannabis.shtml

Note: The Department of Health may verify information on each application and accompanying documentation including an on-site visit.

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Approved: ____ Not Approved: ____

Coordinator Signature: _____

Date: ____