



# Medical Cannabis Program Information Change or Replacement Card

Faxed or electronic copies will not be accepted

Please fill out the following form completely to update your contact information, or to receive a replacement medical cannabis ID card.

**PLEASE PRINT ALL INFORMATION CLEARLY**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ ID Code: \_\_\_\_\_

- ID Card
- Personal Production License (PPL)-**Please note: a change of address for a PPL, must be submitted with a new PPL application for the new location.**

**Reason for replacement card (check one)**

- Card was stolen
- Address Change
- Incorrect Information
- Card was lost
- Did not receive card
- Other: \_\_\_\_\_

If your card contains incorrect information or you require an address change **you must return the incorrect or old card before we can send out your new card.** Once the old card has been returned your new card will be mailed out directly.

Card included with this form

**INCORRECT INFORMATION OR FORMER ADDRESS: (please print clearly)**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

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**Mailing Address:** \_\_\_\_\_

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**City:** \_\_\_\_\_ **County:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

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**Physical Address:** \_\_\_\_\_

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**City:** \_\_\_\_\_ **County:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

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**CORRECTED INFORMATION OR NEW ADDRESS: (please print clearly)**

Please include the **PHYSICAL ADDRESS** as this is the address that is printed on the patient and PPL cards.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

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**Mailing Address:** \_\_\_\_\_

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**City:** \_\_\_\_\_ **County:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

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**Physical Address:** \_\_\_\_\_

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**City:** \_\_\_\_\_ **County:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

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I \_\_\_\_\_ (print patient name) swear or affirm that I never received a Medical Cannabis Program enrollment card; or I did receive this card, but it was stolen, lost or destroyed. I am aware that if I do find or receive my original card at a later date, I must return it immediately to the Department of Health Medical Cannabis Program at the address at the bottom of this form.

I want to pick up my card in person, please notify me when it is ready.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please submit by mail to:**

**NMDOH-Medical Cannabis Program**  
• 1190 St. Francis Dr., Suite N-1050  
• Santa Fe, New Mexico • 87502

medical.cannabis@state.nm.us • [http://www.nmhealth.org/idb/medical\\_cannabis.shtml](http://www.nmhealth.org/idb/medical_cannabis.shtml)

DOH USE ONLY  Old Card Received/Destroyed \_\_\_\_\_ / \_\_\_\_\_ New card created and sent out (picked up)

(initials and date)