Application Checklist

NEW MEXICO DEPARTMENT OF HEALTH

Please print clearly and ensure application is complete. Incomplete or illegible applications or applications with missing documents will delay processing. 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. All forms must have original signatures. **Photocopies, 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 including your New Mexico 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 (NOTE: Some conditions have additional requirements – see below)
  - ☐ For Chronic Pain, an additional board certified specialist certification is required.
  - ☐ For PTSD, current medical records or clinical notes from a psychiatrist or psychiatric nurse practitioner confirming the diagnosis.
  - ☐ For Glaucoma, medical records showing an ophthalmologist's diagnosis.
  - ☐ For Inflammatory Autoimmune-Mediated Arthritis, certification must be signed by a rheumatologist who is board-certified in rheumatology by the American Board of Internal Medicine.
  - ☐ For Hepatitis C Infection, must provide proof of current antiviral treatment.
  - ☐ For Painful Peripheral Neuropathy, submit current medical records documenting objective evidence of the diagnosis.
- ☐ Release of Medical Information Form
- ☐ Clinical/Diagnostic Notes Form completed by the Certifying Practitioner and/or Medical Records.
- ☐ Valid NM issued Photo ID or Driver's License. – PLEASE MAKE SURE IT IS CLEAR AND VISIBLE. **Temporary or Extension IDs are not accepted.**
- ☐ If you wish to produce your own medical cannabis, submit a separate application for a patient Personal Production License (PPL). This must be completed annually or if any information changes, such as location, security, etc.

PLEASE NOTE: OUR APPLICATION PROCESSING TIME IS **30 DAYS FROM THE DATE WE RECEIVE THE COMPLETE APPLICATION. IF YOU HAVE NOT RECEIVED ANYTHING 40 DAYS AFTER SUBMITTING YOUR APPLICATION, PLEASE CONTACT OUR OFFICE**

Send Application to:

Medical Cannabis Program
New Mexico Department of Health
1190 St. Francis Drive S3400
Santa Fe, NM 87502

Contact Information:

Email: medical.cannabis@state.nm.us
Website: www.nmhealth.org/mcp
Telephone number: 505-827-2321

Enrollment/Re-enrollment Information Form

NEW MEXICO DEPARTMENT OF HEALTH

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☐ **New Patient** ☐ **Re-enrolling Patient (Patient ID # :_____) Expiration Date: _____**

☐ **Copy of New Mexico ID or Driver's License Attached.** **(This must be a permanent ID; the program cannot accept Temporary or Extension ID)**

Applicant First Name: _____ Last: _____ Middle: _____

Date of Birth (Month/Day/Year): _____

The following information is optional and is used for statistical purposes only:

__ Hispanic __ White __ American Indian ___ Black or African/American __ Asian

__ Native Hawaiian/Pacific Islander __ Other

The physical address provided below must be your primary physical residence and will appear on your patient card subject to approval.

Once approved, any change of address must be reported, in writing, to our office within ten (10) calendar days.

Is the address below a change of address from previous year applications? _____ Yes _____No

Physical Address: _____

Mailing Address: _____

City: _____ County: _____ Zip Code: _____

Phone Number: _____ Email: _____

Patient Diagnosis: _____

Certifying Medical Provider's Name:

_____

Medical Provider's Office Address:

_____

_____

Secondary/Specialist Medical Provider Name:

_____

Medical Provider's Office Address:

_____

_____

By signing below, I certify that all the information submitted is complete and correct. I also acknowledge that I have read and will abide by the limitations and restrictions on my right to use and possess medical cannabis as stated in the Lynn and Erin Compassionate Use Act and in New Mexico Administrative Code 7.34.3, the full text can be found on the program website http://www.nmhealth.org/mcp.

_____ _____

(Applicant Signature) (Date)

THE ENROLLMENT/RE-ENROLLMENT MEDICAL CERTIFICATION FORM MUST BE COMPLETED IN FULL BY THE MEDICAL PROVIDER.

NMDOH USE ONLY

Date Chart Created: _____ Reviewed By: _____
PPL Application Attached: ____YES ___NO

Medical Cannabis Program • NM Department of Health
1190 St. Francis Drive, S3400 • Santa Fe, New Mexico 87502
(505) 827-2321

Revised 3/20/2014

Enrollment/Re-enrollment Medical Certification Form

NEW MEXICO DEPARTMENT OF HEALTH

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Applicant First Name: _____ **Last:** _____ **Middle Initial:** _____
Patient Date of Birth: (for verification in case of duplicate names) _____/_____/_____

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**
- ☐ **Spasmodic Torticollis (Cervical Dystonia)**
- ☐ **Huntington's Disease**
- ☐ **Parkinson's disease**

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 familiar with patients chronic pain, 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 confirming unremitting severe chronic pain.** This applies to both new applications and re-enrollments).
- ☐ **Post-Traumatic Stress Disorder** (current documentation confirming the diagnosis by a **Psychiatrist or Psychiatric Nurse Practitioner** must be included with this certification).

Written certification MUST be provided pursuant to the *Lynn & Erin Compassionate Use Act of 2007*, medical provider must certify and answer the following questions **as well as provide medical records, diagnostic notes, or signed letter regarding treatment and diagnosis.**

By signing below you are certifying, that based on your in person examination of the patient, the patient's condition is:

- **Chronic and debilitating** ☐ Yes ☐ No
- **You have discussed the potential risks and benefits with the patient and benefits outweigh risk** ☐ Yes ☐ No
- **Standard Treatments have failed to bring adequate relief** ☐ Yes ☐ No
- **If requested you can provide records that reflect history and treatment of diagnosis.** ☐ Yes ☐ No

For re-enrollments, the provider must re-certify that the patient's medical condition still warrants the use of medical cannabis by selecting the answer that applies. Do you believe this person still meets the eligibility requirements for the Medical Cannabis Program? ☐ Yes ☐ No

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." By signing below you are attesting that your primary place of practice is within the State of New Mexico. Further 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.

Provider Name: _____ **Patient in your care for how long?** _____
Provider Email: _____
Provider Clinical Licensure (MD, DO, NP, PA, etc.): _____ **Board Certified Specialty:** _____
Office Address: _____ **City:** _____ **State:** NM **Zip Code:** _____
Mailing Address: _____ **City:** _____ **State:** NM **Zip Code:** _____
Provider Telephone Number: _____ **Second Telephone Number:** _____
NM Medical License #: _____ **DEA License #:** _____
NM Controlled Substance License #: _____

Medical Provider Signature: _____ **Date:** _____
(Must be dated within 90 days of program receipt)

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Date Chart Created: _____ ☐ **Approved** ☐ **Not Approved**
Medical Director Signature: _____ **Date:** _____
MCP Coordinator/Manager Signature: _____ **Date:** _____

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This form must be completed by the certifying medical practitioner and included with all applications.

Date of Visit: _____

Patient Name: _____ Date of Birth: _____

☐ New Patient Application ☐ Renewal Application

Location where Exam Performed: _____

City: _____ State: ____ Zip Code: _____

Diagnosis: _____

☐ Continuing Patient ☐ Initial Visit ☐ Consultation

Have you attached medical records, diagnostic notes, or other records of treatment? ☐ Yes ☐ No

Where are patient records kept? Office _____ Other (explain) _____

Treatment History/History of Diagnosis:

_____
_____
_____
_____
_____

Certifying Practitioners Physical/Mental Health Exam Notes:

_____
_____
_____
_____
_____

For renewal, is the patient maintaining or improving on cannabis? Please Describe:

_____
_____
_____

Recommendations for ongoing treatment:

_____
_____
_____

_____ _____

Practitioner Signature Date of Evaluation

NMDOH USE ONLY

Date Chart Created: _____ ☐ **Approved** ☐ **Not Approved**
Medical Director Signature: _____ **Date:** _____
MCP Coordinator/Manager Signature: _____ **Date:** _____

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Release of Information Form

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

Medical Cannabis Program to discuss my medical condition, including treatment records, test results and

evaluations specific to _____ with the medical providers identified in this application.
(Please Print Qualifying Medical Cannabis Condition)

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 the Department of Health. 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 or failed to adhere to Department of Health regulations.

Participant Signature or Personal Representative: _____

Print Name: _____

Date: _____

This authorization will expire in one (1) year.

If this form is signed by a personal representative, rather than the applicant a witness other than the personal representative must sign below:

Witness Signature_____ Date: _____

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