NEW MEXICO DEPARTMENT OF HEALTH

Caregiver Application

Forms will be returned 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. All forms must have original signatures. **Photocopies, faxed and electronic copies will not be accepted.**

Please keep a copy of all application documents for your records.

1. Caregiver Application Form filled out completely. It must be signed by the:
   - Patient
   - Caregiver, and
   - Certifying medical provider
2. Federal background check
   - This can be completed by any National Criminal Background Check Company online and must be of all 50 States, based on name and date of birth. This type of background check can generally be done through the internet. **Make sure you have the background check sent directly to you. *DO NOT* have it sent directly to the NM Department of Health or the Medical Cannabis Program.**

   (Please note: the NM Medical Cannabis Program cannot provide a recommendation for any specific companies)
3. A copy of the caregiver's valid New Mexico issued photo ID or driver's license
4. Release of medical information to caregiver form, must be signed by enrolled patient.
5. For minors, parental consent form and a copy of birth certificate.

6. If application is signed by a Power of Attorney please attach medical power attorney.

Send Completed Applications to:

Medical Cannabis Program
New Mexico Department of Health
1190 St. Francis Drive, S3400
PO Box 26110
Santa Fe, NM 87502-6110

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Primary Caregiver Information

Please attach a copy of the caregiver's New Mexico ID to this application and a complete national criminal background check. For minors please include a copy of a birth certificate.

Caregiver First and Last Name	Telephone Number	Date of Birth	
If renewal Current Caregiver Number:		Expiration Date:	
Mailing Address:	City:	State:	Zip Code
Physical Address	City	State	Zip Code

Individuals convicted of a felony violation of *Section 30-31-20, 30-31-21, or 30-31-22 NMSA 1978*, or a violation of any equivalent out-of-state statute in any jurisdiction, are prohibited from serving as a primary caregiver. See Caregiver Application Checklist for more information.

By signing below, I acknowledge that: 1.) A qualified patient shall only reimburse their primary caregiver for the cost of travel, supplies or utilities associated with the possession of medical cannabis by the primary caregiver for the qualified patient. **2.)** No other cost associated with the possession of medical use cannabis by the primary caregiver for the qualified patient, including the cost of labor, shall be reimbursed or paid. **3.)** All medical cannabis possessed by a primary caregiver for a qualified patient is the property of the qualified patient. **4.)** The primary caregiver of a qualified patient who holds a personal production license **may assist** the qualified patient to produce medical cannabis **only** at the **designated licensed location**, identified on the qualified patient's personal production license. **5.)** The primary caregiver **may not independently** produce medical cannabis.

Caregiver Signature: _____ Date: _____

Patient Information

Patient First and Last Name	Telephone Number	Date of Birth	
If renewal Current Patient Number:		Expiration Date:	
Mailing Address:	City:	State:	Zip Code
Physical Address	City	State	Zip Code

By signing below, the qualified Patient agrees that this primary caregiver-applicant is necessary to take responsibility for managing the well-being of the Patient with respect to the use of medical cannabis in accordance with the Lynn and Erin Compassionate e Use Act.

Qualified Patient signature: _____ Date: _____

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Certifying Medical Provider

Certifying Provider First and Last Name	Telephone Number	Medical License Number	
Mailing Address:			
City	State	Zip Code	
Medical Justification for Caregiver			

By signing below, both the Patient and the Patient's Certifying Medical Provider agree that this patient is in need of somebody to manage their well being and that caregiver-applicant is capable of assisting the Patient to acquire and administer Medical Cannabis in accordance with the Lynn and Erin Compassionate Use Act.
Patient Signature: _____ _____ Date: _____
Certifying Medical Provider Signature: _____ Date: _____

All required forms must be submitted in order for your application to be considered.

PLEASE ENSURE CAREGIVER HAS INCLUDED CRIMINAL BACKGROUND CHECK AND NEW MEXICO ISSUED IDENTIFICATION. FOR A MINOR INCLUDE A BIRTH CERTIFICATE. IF THE APPLICANT IS NOT A MINOR AND ANOTHER PARTY SIGNS ON THEIR BEHALF PLEASE INLCUDE THE MEDICAL POWER OF ATTORNEY.

NMDOH USE ONLY
□ Approved □ Not Approved
Medical Director/Coordinator Signature: _____ Date: _____

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Release of Medical Information to Caregiver Form
(To be completed by enrolled patient)

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A caregiver is someone empowered by a patient to help the patient manage his/her medical care and medication. Completing this form gives our program permission to discuss issues concerning you participation as a patient in the Medical Cannabis Program with your Caregiver. ***You are not required to have a Caregiver in order to register in the Medical Cannabis Program.***

I, _____ hereby authorize the New Mexico Department of Health's Medical
Cannabis Program to discuss my participation in the Medical Cannabis Program with my Caregiver,
_____.
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 that re-disclosure may not be protected by the HIPAA privacy rule. I understand that this release is voluntary and that signing this form is not necessary in order to receive treatment from DOH. This release is required, however, to verify a patient's eligibility for the Medical Cannabis Program. By signing this release, I certify that I am aware that the program will verify my enrollment and caregiver 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: ___/___/___.

Printed Name of Program Participant or Personal Representative:
_____
Signature of Program Participant or Personal Representative:
_____
Date: _____

If this form is signed by a **personal representative**, a witness must sign below:
Witness Signature: _____ Date: _____

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New Mexico Department of Health Medical Cannabis Program
Qualified Minor Parental Consent Form
(This form is only required if applicant is under 18 years of age)

I, _____, pursuant to the Lynn & Erin Compassionate Use Act of 2007, do hereby declare:

1. I am the Parent or Legal Custodian of:
Qualified Minor's Name: _____

2. The Qualified Minor's medical provider has explained the potential risks and benefits of the use of medical cannabis to the Qualified Minor and to me as the Parent or Legal Representative of the aforementioned Qualified Minor.

3. I consent to the qualified minor's use of medical cannabis.

4. I agree to serve as the qualified minor's primary caregiver; AND

5. I agree to control the acquisition, dosage, and frequency of the medical cannabis used by the qualified minor.

Signature: _____ **Date:** _____

Parent or Legal Custodian Contact Information:

Name: _____
Date of Birth: _____
Address: _____
_____

Social Security Number: _____**Telephone Number:** _____