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.

- ☐ Information Form filled out completely. If signed by a representative please include medical power of attorney.
- ☐ Medical Certification Form filled out completely. It is recommended that medical records regarding the diagnosis be included.
- ☐ 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 application is for a minor please include a copy of the minor's birth certificate.**
- ☐ 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.

Once complete, please mail application to the Medical Cannabis Program Mailing Address

There is currently no fee for the patient enrollment card.

Contact Information

Mailing Address: Department of Health
Medical Cannabis Program
PO Box 26110
Santa Fe, NM 87502-6110

Physical Address: Department of Health
Medical Cannabis Program
1474 Rodeo Road Suite 200
Santa Fe, NM 87505

Website: www.nmhealth.org/go/mcp

Telephone Number: 505-827-2321

Enrollment/Re-enrollment Information Form

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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) For minors please include a copy of the birth certificate.**

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.

Please avoid using Number sign (#), hyphens (-), or periods (.) in addresses and names.

Is the address below a change of address from previous year applications?_____Yes_____No

Mailing Address: _____

City: _____ County: _____ Zip Code: _____

Enrollee Physical Address: _____

City:_____County:_____Zip Code: _____

Phone Number: _____ Email: _____

Patient Diagnosis: _____

Certifying Medical Provider's Name:

_____

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 at: nmhealth.org/go/mcp

_____ _____

(Applicant Signature) (Date)

NMDOH USE ONLY

Date Chart Created:_____Reviewed By: _____

PPL Application Attached:____YES___NO

Check Number _____

Caregiver _____ Yes _____ No

Revised 06-20-2016

Mailing Address:

Medical Cannabis Program • NM Department of Health

PO Box 26110 Santa Fe, NM 87502 (505) 827-2321

Physical Address: 1474 Rodeo RD Suite 200

Santa Fe, NM 87505

Enrollment/Re-enrollment Medical Certification Form

NEW MEXICO DEPARTMENT OF HEALTH

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

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)

Statutory Approved Conditions

- ☐ **Amyotrophic Lateral Sclerosis (ALS)**
- ☐ **Cancer** (please specify type) _____
- ☐ **Crohn's Disease**
- ☐ **Epilepsy**
- ☐ **Glaucoma**
- ☐ **Hepatitis C Infection currently receiving antiviral treatment** (proof of current anti-viral treatment required)
- ☐ **HIV/AIDS**
- ☐ **Huntington's Disease**
- ☐ **Hospice Care**
- ☐ **Inclusion Body Myositis**
- ☐ **Inflammatory autoimmune-mediated arthritis**
- ☐ **Intractable Nausea/Vomiting**
- ☐ **Multiple Sclerosis**
- ☐ **Damage to the nervous tissue of the spinal cord, *with*** (proof of objective neurological indication of intractable spasticity required)
- ☐ **Painful Peripheral Neuropathy**
- ☐ **Parkinson's disease**
- ☐ **Post-Traumatic Stress Disorder**
- ☐ **Severe Chronic Pain**
- ☐ **Severe Anorexia/Cachexia**
- ☐ **Spasmodic Torticollis (Cervical Dystonia)**
- ☐ **Ulcerative Colitis**

By signing below you are certifying that, based on your in-person examination of the patient:

- **The patient's condition is chronic and debilitating.**
- **You have discussed the potential risks and benefits with the patient, and find that potential health benefits of the medical use of cannabis likely outweigh the health risks for the patient.**

The New Mexico Department of Health, Medical Cannabis Program will verify the information provided within 30 days of receiving a completed 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*, i.e.: "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 agreeing to have patient medical records audited as necessary to verify the application.

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)

NMDOH USE ONLY

Date Chart Created: _____ ☐ **Approved** ☐ **Not Approved**
Medical Director Signature: _____
Date: _____

Medical Cannabis Program • NM Department of Health
PO Box 26110 • Santa Fe, NM 87502
(505) 827-2321

Revised 6-16-2016

Medical Provider Clinical/Diagnostic Notes Form

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This form must be completed by the certifying medical practitioner and be included with all applications.
The information provided below is used by the Department to verify the application.

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

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 Department in accordance with the Lynn and Erin Compassionate Use Act and/or HIPAA; and in the event that the information is re-disclosed, the information may no longer 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, including but not limited 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: _____