NEW MEXICO DEPARTMENT OF HEALTH

Medical Cannabis Program

Website: www.nmhealth.org/go/mcp **Telephone Number**: 505-827-2321

There is no charge to apply for a patient ID card. There is a $50 charge for a replacement card.

An application that is not complete or hard to read may delay your card.

Submit only ORIGINAL pages of the application. The program cannot accept photocopies, faxes or electronic copies.

Please keep a copy of everything you send in, including a copy of your New Mexico ID.

Please submit renewal applications at least 30 days before your card expires. Renewal applications can be submitted up to 90 days before your card's expiration date.

Checklist and Instructions for Patient Applications

This application is for new applicants and current/renewing patients.
You can use the checklist to be sure you have everything for your application.

☐ Completed "Patient Information Form" (Page 1): Filled out by you (the patient).

- Make sure your form is complete and all the information is correct.
- *NOTE*: Your mailing address is where you want your card sent. Your street address is where you stay most nights.

☐ Completed "Medical Certification Form" (Page 2): Filled out by your medical provider.

☐ Clear copy of your **current** New Mexico Driver's License or New Mexico photo ID.

- Temporary IDs will be accepted with photocopies of BOTH the temporary paper ID and the expired or old ID with the hole punched in it.

☐ Copy of clinic notes: Ask your Medical Provider for a copy of these.

☐ Sign and date the form. This must be an ORIGINAL signature not a photocopy.

- If the patient is 18 years old or older and the form is signed by someone else, please send proper legal papers that show this signature is allowed by law (usually Medical POA or Guardianship). If the patient is too ill to sign for themselves, the patient and the person signing this form should consider completing a "Caregiver Application" so that they may assist the patient with their medical cannabis.
- If the patient is under 18 years old, please include a copy of the patient's birth certificate. The person signing the form must be a parent or guardian and complete a "Caregiver Application".

Once complete, please mail or drop off your application to the Medical Cannabis Program:

Mail To:
Department of Health
Medical Cannabis Program
1190 S St. Francis Dr., PO Box 26110
Santa Fe, NM 87502-6110

Drop Off To:
Department of Health
Medical Cannabis Program
1474 Rodeo Road, Suite 200
Santa Fe, NM 87505

If you are a patient and want to grow your own medical cannabis, complete and send in the application for a Personal Production License (PPL).

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Patient Information Form

TO BE COMPLETED BY THE PATIENT

○ New Patient ○ Renewing Patient (Already in program even if card has expired)

First Name: _____ **Last Name**: _____

Middle Name: _____ Suffix (e.g. Sr., Jr.): _____

Date of Birth (MM/DD/YYYY): _____ Phone Number: _____

Email Address: _____

How would you describe yourself?

☐ Man ☐ Woman ☐ Transgender ☐ Transgender Man ☐ Transgender Woman ☐ Other: _____

Mailing Address: _____ Street Address: _____

City: _____ City: _____

County: _____ County: _____

Zip: _____ Zip: _____

Questions in this box are optional. Your answers help us better serve people in the program.
If you don't want to answer something, leave it blank.

Please check the race or ethnicity you call yourself. Check all that apply.

☐ American Indian or Alaska Native
Tribe: _____
☐ Asian
☐ Black or African American
☐ Latino or Hispanic American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other: _____

Are you a Veteran? ○ Yes ○ No

Language you speak most often: _____

Applicant Signature: **I have included a COPY OF MY NM STATE ID.** By signing below, I agree that:

All the information given above is complete and correct.

I will follow the limits and restrictions on my right to have and use medical cannabis that are in the laws of New Mexico (the Lynn and Erin Compassionate Use Act and the New Mexico Administrative Code 7.34.3). These laws are on the program's website at: nmhealth.org/go/mcp.

I allow the New Mexico Department of Health, Medical Cannabis Program to discuss my medical condition, including treatment records, test results and evaluations specific to enrollment in the Medical Cannabis Program with the medical provider(s) named in this application.

_____ _____

Applicant Signature* (Please print form - then sign) Date

* If signed by someone other than the applicant, send proper legal documents (see instructions for more information)

Mail to: DOH - Medical Cannabis Program; 1190 S St. Francis Dr.; PO Box 26110; Santa Fe, NM; 87502-6110

NMDOH USE ONLY

Date Card Printed: _____ Reviewed By: _____ Caregiver App Attached: ☐ YES ☐ NO

PPL App Attached: ☐ YES ☐ NO Check Number: _____

Disclosure Form on File: ☐ YES ☐ NO Unit Increase Letter Attached: ☐ YES ☐ NO

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Medical Certification Form

TO BE COMPLETED BY A MEDICAL PROVIDER

Applicant Full Name: _____ Date of Birth (MM/DD/YYYY): _____

Location of Exam: _____ Patient in your care for how long: _____

Medical Reason for Provider Certification - ***Please check all that apply. Circle the primary certifying condition.***

- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Cancer *(please specify type in clinical notes)*
- ☐ Crohn's Disease
- ☐ Epilepsy/Seizure Disorders
- ☐ Glaucoma
- ☐ HCV infection **and** receiving antiviral treatment currently *(please provide proof of antiviral treatment in clinical notes)*
- ☐ 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 *(please provide proof of objective neurological indication of intractable spasticity in clinical notes)*
- ☐ Painful Peripheral Neuropathy
- ☐ Parkinson's Disease
- ☐ Post-Traumatic Stress Disorder
- ☐ Severe Chronic Pain
- ☐ Severe Anorexia/Cachexia
- ☐ Spasmodic Torticollis (Cervical Dystonia)
- ☐ Ulcerative Colitis
- ☐ Obstructive Sleep Apnea

PLEASE ATTACH the most recent clinic notes confirming the applicant's diagnosis

Provider Name: _____ Clinical Licensure (MD, DO, NP, PA, etc.): _____

Board Certified Specialty: _____ NM Medical License #: _____

DEA License #: _____ NM Controlled Substance License #: _____

Office Address: _____ City: _____ State: NM Zip: _____

Mailing Address: _____ City: _____ State: NM Zip: _____

Provider Telephone Number: _____ Second Telephone Number: _____

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;
- You understand the Medical Cannabis Program needs **clinical records annually** for verification purposes; and
- You are licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act and your primary practice is in New Mexico.

Medical Provider Signature: _____ Date: _____

(Please print form - then sign) (Must be dated within 90 days of receipt by program)

NMDOH USE ONLY

Program Staff Signature: _____ Date: _____

☐ Approved ☐ Denied ☐ Request for Records Sent ☐ Additional notes in BioTrack

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Instructions for Providers

Practitioners must have a physician-patient relationship with the qualified patient and conduct in-person evaluations of the qualified patient prior to issuing a certification.

PLEASE PRINT CLEARLY or TYPE THE APPLICATION – The form can be completed using a computer then printed and signed, or it can be handwritten.

Page 1 - Completed by the patient including their name, demographics, current address, current telephone number, and **original** signature (photocopies not accepted).

Page 2 - Filled out by a medical provider (e.g. Doctor, Nurse Practitioner, prescribing Psychologist, Dentist, etc. who is allowed by law to prescribe controlled substances in the state of New Mexico). *Please Note:* Resident Physicians and Fellows do not have the credentials necessary to meet regulatory requirements. Please have attending physicians complete the certification.

- Ensure the following information is present:
  - Patient's legal name and date of birth (matching the patient's state ID);
  - The address where the exam took place and how long this patient has been in your care;
  - Reason for provider's certification (i.e., approved condition/diagnosis);
    - Check all conditions that apply to the patient and circle the primary certifying condition.
  - Provider's information;
    - Name, clinical license held, and board specialty;
    - NM Medical License number;
    - Federal DEA License number;
    - NM Controlled Substance License number;
    - Office address, mailing address, and phone numbers.
  - **Original** provider signature and date (photocopies not accepted).
- **Medical notes must be attached** to the form to provide additional support for the patient's application. Ensure these materials are submitted with the application.

All original pages of the application, a photocopy of the patient's current New Mexico State ID (i.e., driver's license or state issued ID card) and supporting documents should be submitted together. This may be done by the patient or the practitioner.

A practitioner shall not be subject to arrest or prosecution, penalized in any manner or denied any right or privilege for recommending the medical use of cannabis or providing written certification for the medical use of cannabis as per NM statue.