NEW MEXICO DEPARTMENT OF HEALTH

Medical Cannabis Program

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

Checklist for Patient Applications

This checklist is for new applicants and current patients ("renewing" patients). You can use it to be sure you have all the documents you need for your application.

There is no charge for the patient ID card (there is a $50 charge for a replacement card).

An application that isn't complete or hard to read may delay your card. You will be notified, and your application will be held for up to 6 months. If it's still not complete, a new application will be needed.

Submit ORIGINAL pages to the Medical Cannabis Program. The program cannot accept photocopies, faxes or electronic copies.

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

Renewal applications can be submitted in up to 90 days prior to your cards expiration date.

☐ Completed "Patient Information Form" (Page 1).

- Use the attached instructions to help you make sure your form is complete.

☐ Completed "Medical Certification Form" (Page 2).

- This is filled out by your medical provider.

☐ Copy of clinic notes.

- Ask your medical provider for these.

☐ Clear copy of a valid New Mexico photo ID or Driver's License.

- "Temporary" or "Extension" IDs will be accepted with BOTH the paper copy and hole punched or old ID.

☐ For those under the age of 18, a clear copy of the birth certificate and a completed "Caregiver Application" and the documents needed for that application.

☐ For those 18 years old or older who need a caregiver, a completed "Caregiver Application" and the documents needed for that application.

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

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

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

If you want to grow your own medical cannabis, complete and send in the application for a Personal Production License (PPL). This is for patients **only** and must be completed annually and when any information changes.

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Instructions for Patient Applications

This application is for new applicants and current patients ("renewing" patients).

There is no charge for patient cards (there may be a charge if a card is lost).

PLEASE PRINT CLEARLY or TYPE YOUR APPLICATION – The form can be completed using a computer and then printed. If you do not have a computer/printer, handwritten forms are fine.

Page 1 – Filled out by you (the patient) or your caregiver (if you have/need one – refer to the Caregiver Application or call 505-827-2321 for more information about this).

- Check one of the boxes to tell us if you are a new applicant or renewing (current) patient.
- Write or type in:
  - Your first, middle, and last name and any suffix like Sr. or Jr. (matching your state ID);
  - Your gender, date of birth (MM/DD/YYY), and the language you speak most often;
  - The address where you want your mail sent (mailing address);
  - The address where you stay most nights (physical address); and
  - Your phone number and email address (if you have one).
- The questions in the box are optional but your answers help us better serve people in the program. Fill out the items you feel comfortable answering. Leave the rest blank.
- 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 shows this signature is allowed by law. The person signing the form must also complete a "Caregiver Application".
  - If the patient is under 18 years old and the form is signed by someone else, please include a copy of the patient's birth certificate. The person signing the form must also complete a "Caregiver Application".
- Make a clear copy of your NM State ID (driver's license or state issued ID card) to include with your application.
  - If you have a temporary ID, make a copy of the paper/temporary ID and the old ID that had a hole punched in it by the Motor Vehicles Division (MVD). Send both photocopies with the application.

Page 2 – Filled out by your medical provider (e.g., doctor, nurse, psychologist, dentist, etc. who is allowed by law to prescribe medicine in the state of New Mexico).

- Be sure your provider fills in everything and signs the form. These must be ORIGINAL signatures.
- The application must be received by the Medical Cannabis Program within 90 days from the date that the provider signs the form.

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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: _____ Middle Name: _____

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

How would you describe yourself?

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

Date of Birth (MM/DD/YYYY): _____ Language you speak most often: _____

Mailing Address: _____ City: _____

County: _____ Zip: _____

Physical Address: _____ City: _____

County: _____ Zip: _____

Phone Number: _____ Email: _____

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

Applicant Signature: 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 and 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 currently receiving antiviral treatment *(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

PLEASE ATTACH 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 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-client 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, 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 no 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;
    - NM Controlled Substance License number;
    - Federal DEA 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.