

Medical Cannabis Program

Website: www.nmhealth.org/go/mcp

Telephone Number: 505-827-2321

Checklist for Primary Caregiver Applications

This checklist is for the Primary Caregivers of new and current patients (“renewing” patients). You can use it to be sure you have everything you need for your application.

There is no charge for the Primary Caregiver 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. 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 at this time.

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

- Completed “Patient Application” for the patient who needs a Primary Caregiver (unless the person is already a patient).
- Completed NATIONWIDE background check, done by any national criminal background check company, for all 50 States based on social security number and date of birth (see “Instructions for Primary Caregivers” for more information).
- Completed “Primary Caregiver Information and Patient Information Form” (Page 1).
 - Use the attached instructions to help you make sure your form is complete.
- Completed “Medical Certification Form for Primary Caregivers” (Page 2).
 - This is filled out by the patient’s medical provider.
- For those under the age of 18, a clear copy of the patient’s birth certificate and a completed “Qualified Minor Parental Consent Form” (Page 4).
- Clear copy of the Primary Caregiver’s 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 18 years old or older, include the legal documents that allow you to make medical decisions for this patient. This may be “Medical Power of Attorney”, or “Guardianship” papers.

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

Instructions for Primary Caregiver Applications

This application is for the Primary Caregiver of new applicants and current patients (“renewing” patients).

There is no charge for a Primary Caregiver ID card (there is a \$50 charge for a replacement card).

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.

Before starting the Primary Caregiver’s application, start the process of getting a nationwide background check. Companies who do this type of background check can generally be found through the internet (search for “national criminal background check company”). The NM Medical Cannabis Program does make recommendations for specific companies. ***Please note: Have the documents sent to you.*** You will send these in with your application.

Page 1 – Filled out by you (the Primary Caregiver) and the patient.

- Write or type in the following information for you and the patient:
 - First, middle, last name and date of birth (matching your state IDs);
 - Address where mail should be sent (mailing address) and the address where you or the patient stay most nights (physical address); and
 - Phone numbers and email addresses (if there are email addresses).
- Both you and the patient need to sign and date the form in the right places. These must be ORIGINAL signatures not photocopies.
 - 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 is allowed by law (may be Medical Power of Attorney or guardianship papers from a court of law).
 - If the patient is under 18 years old and the form is signed by a parent or guardian, please include a copy of the patient’s birth certificate or guardianship papers from a court of law.
- 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 copies of both with the application.

Page 2 – Filled out by the patient’s 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.

Page 3 – “Parental Consent Form for Minors” is only needed if the patient is under 18 years of age.

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Primary Caregiver Information

Individuals convicted of a felony violation for trafficking of controlled substances (*NMSA Section 30-31-20*), distribution of a controlled substance to a minor (*NMSA Section 30-31-21*), or the prohibited distribution of a controlled or counterfeit substance (*NMSA Section 30-31-22*), or a violation of any equivalent statute in another state or country, cannot serve as a Primary Caregiver.

First Name: _____ Middle Name: _____
Last Name: _____ Date of Birth (MM/DD/YYYY): _____
Mailing Address: _____ City: _____
County: _____ Zip: _____
Physical Address: _____ City: _____
County: _____ Zip: _____
Phone Number: _____ Email: _____

I (the Primary Caregiver) agree that all the information is complete and correct. I agree to take responsibility for managing the well-being of the qualified patient named in this application with respect to their medical use of cannabis. I will follow the rights and restrictions to serve as a Primary Caregiver to a Medical Cannabis Patient that are in the laws of New Mexico*.

(Primary Caregiver Signature) (Please print form then sign)

(Date)

Patient Information

First Name: _____ Middle Name: _____
Last Name: _____ Date of Birth (MM/DD/YYYY): _____
Mailing Address: _____ City: _____
County: _____ Zip: _____
Physical Address: _____ City: _____
County: _____ Zip: _____
Phone Number: _____ Email: _____

I (the Patient) agree that all the information is complete and correct. I agree that this application is necessary to help manage my well-being while using medical cannabis according to the laws of New Mexico*.

(Patient Signature**) (Please print form then sign)

(Date)

* The Lynn and Erin Compassionate Use Act and the NM Administrative Code 7.34.3 can be found at nmhealth.org/go/mcp.

** If signed by someone other than the applicant, send legal documents to show this is allowed by law (may be a Medical Power of Attorney or Guardianship papers).

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Primary Caregiver Medical Certification Form

TO BE COMPLETED BY A MEDICAL PROVIDER

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

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: _____

Medical justification for the patient's need for a Primary Caregiver: _____

By signing below, you are certifying that the patient is in need of assistance managing their well-being and that the person applying to be the patient's Primary Caregiver is capable of assisting the patient with acquisition and administration of medical cannabis in accordance with the laws of New Mexico (The Lynn and Erin Compassionate Use Act and the NM Administrative Code 7.34.3. These laws are on the program's website at: nmhealth.org/go/mcp).

Medical Provider Signature: _____ Date: _____
(Please print form then sign) (Must be dated within 90 days of program receipt)

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

NMDOH USE ONLY

Program Staff Signature: _____ Date: _____

Approved Denied Additional notes in BioTrack

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Parental Consent Form for Minors

REQUIRED FOR APPLICANTS UNDER 18 YEARS OF AGE

I, _____, following New Mexico State Law (the Lynn & Erin
(Print Parent's Name)

Compassionate Use Act and the NM Administrative Code 7.34.3), certify the following:

- I am the Parent (or Legal Guardian) of _____
(Print Minor's Name)
- The minor's medical provider has explained the potential risks and benefits of the use of medical cannabis to the minor and to me as the parent or legal representative of the minor;
- If approved, I consent to the minor's use of medical cannabis;
- If approved, I agree to serve as the minor's Primary Caregiver; AND
- If approved, I agree to control the acquisition, dosage, and frequency of the medical cannabis used by the qualified minor.

Parent's First Name: _____

Parent's Last Name: _____

Parent's Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

Mailing Address: _____

City: _____

County: _____

Zip: _____

Parent's Signature

(Please print form then sign)

Date