NEW MEXICO Department of Health
Medical Cannabis Division

Medical Cannabis Program

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

There is no charge to apply or to renew a patient ID card.

Please print or type responses since an incomplete or difficult to read application may delay the process.

Send the ORIGINAL signed page of the application. Photocopies of signature pages cannot be accepted.

Send all required items in one packet.

This form should be completed by you and a medical provider who has a physician-patient relationship with you.

Keep a copy of everything you send, including a copy of your New Mexico ID, for your records.

Remember to send annual certification or renewal applications at least 30 days before annual certification or expiration date to remain enrolled in the Medical Cannabis Program.

Checklist and Instructions for Paper Applications

This application is for both new applicants and current/renewing patients.

You can use the checklist to be sure you have everything needed for your application.

- ☐ Complete the Patient Information: the patient should make sure all the information is correct.
- ☐ Complete the Medical Provider Section: the medical provider must indicate the primary qualifying condition and provide contact information and license number.

- ☐ The patient must include a clear (face visible) copy of your **current** New Mexico Driver's License or New Mexico photo ID. Temporary New Mexico Driver's License and photo IDs are acceptable.
- ☐ Include a copy of a one-page clinic note related to qualifying condition (see application for details).
- ☐ The form must be dated and have ORIGINAL signatures by both the patient and the medical provider. These cannot be photocopied.
  - If the patient is 18 years old or older and the form is signed by someone else, please send a completed Medical Power of Attorney or Legal Guardianship paperwork to indicate legal authority.
  - For any patient under 18 years old the following must also be included:
    - A Caregiver Application with all required documents completed by a Parent or Guardian; and
    - A copy of the *patient's* birth certificate.

  Note: If you are submitting your annual medical certification and need a new card, please also complete and send an Information Change/Replacement Card form because a new card will not be automatically issued for the annual medical certification.

Once complete, please mail or drop off. Faxed applications are not accepted.

Mail To: **Department of Health**
Medical Cannabis Program
PO Box 26110
Santa Fe, NM 87502-6110

Drop Off To: please do not mail to this address
Department of Health
Medical Cannabis Program
1474 Rodeo Road, Suite 200
Santa Fe, NM 87505

NEW MEXICO Department of Health
Medical Cannabis Division

Medical Cannabis Program Patient Application

Mailing Address: Medical Cannabis Program
PO Box 26110 Santa Fe, NM 87502
Telephone Number: 505-827-2321
Website: nmhealth.org/go/mcp
Patient Portal: mcp-patient-tracking.nmhealth.org

This Box -NMDOH Use Only

- ☐ Caregiver Application Attached
- ☐ HIPAA/Medical POA
- ☐ First Annual
- ☐ Second Annual
- ☐ Print
- ☐ New Application

This form to be completed by the Medical Provider and signed by both the Medical Provider and Patient

Check this box if submitting an annual and you need a new card because your card is lost or damaged. ☐

There is no fee for a card or to enroll in MCP. Your medical provider may charge a fee for their services.

Name: _____ Date of Birth(mm/dd/yyyy): _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Telephone Number: _____

Qualifying Conditions *Check Only ONE:*

- ☐ Alzheimer's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Anorexia (severe)/Cachexia
- ☐ Autism Spectrum Disorder
- ☐ Cancer
- ☐ Crohn's Disease
- ☐ Damage to the Nervous Tissue of the Spinal Cord
- ☐ Epilepsy/Seizure Disorder
- ☐ Friedreich's Ataxia
- ☐ Glaucoma
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hospice Care
- ☐ Huntington's Disease
- ☐ Inclusion Body Myositis
- ☐ Inflammatory Autoimmune-mediated Arthritis
- ☐ Intractable Nausea/Vomiting
- ☐ Lewy Body Disease
- ☐ Multiple Sclerosis
- ☐ Obstructive Sleep Apnea
- ☐ Opioid Use Disorder
- ☐ Painful Peripheral Neuropathy
- ☐ Parkinson's Disease
- ☐ Post-traumatic Stress Disorder
- ☐ Severe Chronic Pain
- ☐ Spasmodic Torticollis (Cervical Dystonia)
- ☐ Spinal Muscular Atrophy
- ☐ Ulcerative Colitis

Provider Name: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Telephone Number: _____

Medical Provider email: _____ NM Controlled Substance Number: _____

Copy of Patient's New Mexico ID or Driver's License Attached ☐ **Copy of Certifying Provider's Medical Notes Attached** ☐

By signing below, you are certifying as a medical provider/practitioner:

- I have conducted an appropriate examination of the qualified patient during the preceding twelve months.
- The qualified patient continues to have the qualifying debilitating medical condition identified above.
- I believe the potential health benefits of the medical use of cannabis would likely outweigh the health risks for the qualified patient.
- I have included a one-page copy from the patient medical record which includes the diagnosis as well as the name and contact information of the practitioner who created the medical record and have retained the full patient medical record in accordance to statutory and regulatory requirements as determined by my licensure board pertaining to medical record retention. These records may be required for subsequent program review.

★ Medical Provider Signature:_____ Date: _____

Original signature is required - Please print the form - then sign. Must be dated no more than 90 days prior to the receipt of the application by program.

By signing below, you are confirming you are the patient and have read and agree to adhere to the Rules and Regulations of the State of New Mexico Medical Cannabis Program. The complete rules and regulations are available at: https://nmhealth.org/about/mcp/svcs/

★ Patient Signature:_____ Date: _____

Original signature is required - Please print the form - then sign. Must be dated no more than 90 days prior to the receipt of the application by program.

Questions in this area are optional

Do you think of your self as:

- ☐ Male ☐ Female
- ☐ Transgender man/trans man/female to male (FTM)
- ☐ Transgender woman/trans woman/male-to-female (MTF)
- ☐ Gender Queer/gender nonconforming neither exclusively male nor female
- ☐ Additional Gender category (or other), please specify:_____

What sex was originally listed on your birth certificate?

- ☐ Male
- ☐ Female
- ☐ Decline to answer

Which racial group do you think of you self as:

- ☐ American Indian or Alaska Native persons/communities/populations
- ☐ Asian Persons ☐ Hispanic or Latino Person
- ☐ Black or African American persons, Black persons
- ☐ Native Hawaiian Persons ☐ Pacific Islander Persons
- ☐ White Persons ☐ More than one race;multiple races