NEW MEXICO
DEPARTMENT OF
HEALTH

Caregiver Application Checklist

Please print clearly - Applications will not be processed if any portion is left blank. 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.

Faxed and electronic copies will not be accepted.

Please keep a copy of all application documents for your records.

For Caregiver Applications:

- ☐ Caregiver Application Form filled out completely. It must be signed by the:
  - Patient
  - Caregiver, and
  - Certifying medical provider.

- ☐ Federal background check (this must be completed annually upon re-enrollment as a caregiver)
  - This must include all 50 states and be a lifetime check
  - This can be completed by any organization which conducts national background checks,
    - The NM Department of Public Safety (DPS) - (505) 827-9182 can provide fingerprinting and supply the FBI packet for a federal background check at their Santa Fe office or DPS can mail you the federal background check packet for the FBI.
    - Other fingerprinting locations are available throughout the state.
    - The FBI background check can take from six to eight weeks.
    - For further information go to http://www.dps.nm.org/divisions/tsd/fp_info.php

    Make sure you have the background check sent to you!!!
    ***DO NOT* have it sent directly to the NM-Department of Health or the Medical Cannabis Program!**
    (Please note: the NM Medical Cannabis Program does not provide fingerprint cards)

- ☐ A copy of the caregiver's valid New Mexico issued Photo ID or Driver's License.

- ☐ Release of Medical Information to caregiver form.

Send Completed Application to:

Medical Cannabis Program
New Mexico Department of Health
1190 St. Francis Drive Suite S-1300
Santa Fe, NM 87502-6110

Contact Information
Email: medical.cannabis@state.nm.us
Website: http://www.nmhealth.org/idb/medical_cannabis.shtml

DA/JM 1/24/11

Caregiver Information Form

Please print clearly - This form will be returned to the patient/caregiver without further processing if any portion is left blank. 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.

Faxed and electronic copies will not be accepted.

Caregiver Information:

First Name and Last Name	Telephone Number	Date of Birth
Mailing Address:		
City:	**County:**	**Zip Code:**
Physical Address:		
City:	**County:**	**Zip Code:**

Individuals convicted of a felony violation of *Section 30-31-20, 30-31-21, or 30-31-22 NMSA 1978*, or a violation of any equivalent out-of-state statute in any jurisdiction, are prohibited from serving as a primary caregiver. If an applicant has been convicted of a felony violation of *Section 30-31-1 et seq. NMSA 1978*, other than *Sections 30-31-20 through 30-31-22*, and the final completion of the entirety of the associated sentence of such felony conviction has been less than three (3) years from the date of the applicant's application as a primary caregiver, then the applicant is prohibited from being a primary caregiver. If the applicant has been convicted of more than one (1) felony violation of Section 30-31-1 et seq. NMSA 1978 or a violation of an equivalent out-of-state statute in any jurisdiction, the applicant and qualified patient shall be notified that the applicant is permanently prohibited from being a primary caregiver and cannot be issued a medical use cannabis registry identification card.

By signing below, I acknowledge that: 1.) A qualified patient shall only reimburse their primary caregiver for the cost of travel, supplies or utilities associated with the possession of medical cannabis by the primary caregiver for the qualified patient. 2.) No other cost associated with the possession of medical use cannabis by the primary caregiver for the qualified patient, including the cost of labor, shall be reimbursed or paid. 3.) All medical cannabis possessed by a primary caregiver for a qualified patient is the property of the qualified patient. 4.) The primary caregiver of a qualified patient who holds a personal production license may assist the qualified patient to produce medical cannabis only at the designated licensed location, identified on the qualified patient's personal production license. 5.) The primary caregiver may not independently produce medical cannabis.

Caregiver Signature:____ **Date:** ____________________

Patient Information:

First Name and Last Name	Telephone Number	Date of Birth	Medical Cannabis Registry I.D. #
Mailing Address:			
City:	**County:**	**Zip Code:**	
Physical Address:			
City:	**County:**	**Zip Code:**	

Patient's Current Certifying Medical Provider Information ***(This must be the Patient's current certifying medical provider)***

Name of Certifying Medical Provider	Telephone Number	NM Medical License #
Mailing Address:		
City:	**County:**	**Zip Code:**

By signing below, both the Patient and the Patient's Certifying Medical Provider agree that this caregiver-applicant is capable of assisting the Patient to acquire and administer Medical Cannabis in accordance with the Lynn and Erin Compassionate Use Act.

Patient Signature:____ **Date:** ____________________

Certifying Medical Provider Signature:_______________________________ **Date:** ____________________

*A completed **National Background Check** and a copy of the Caregiver-applicant's **Valid New Mexico Photo ID** is to be submitted with this Caregiver application. The required national background check forms can be found online at *http://www.dps.nm.org/lawEnforcement/records.php* through the Department of Public Safety website. **All required forms must be submitted in order for your application to be considered.**

NMDOH USE ONLY

☐ Approved ☐ Not Approved

Medical Cannabis Director/Coordinator Signature:________________________________ Date:____________________

DA 3/29/11

Release of Medical Information to Caregiver Form

Please print clearly - This form will be returned to the patient/caregiver without further processing if any portion is left blank. 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.

Faxed and electronic copies will not be accepted.

A caregiver is someone empowered by a patient to help the patient manage his/her medical care and medication. Completing this form gives our program permission to discuss issues concerning your participation as a patient in the Medical Cannabis Program with your Caregiver.

You are not required to have a Caregiver in order to register in the Medical Cannabis Program.

I, ______________________________ hereby authorize the New Mexico Department of Health Medical
(Please Print Patient Name)
Cannabis Program to discuss my participation in the Medical Cannabis Program with
__________________________________, my Caregiver.
(Please Print Caregiver's Name)

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 recipient, and that re-disclosure may not be protected by the HIPAA privacy rule. I understand that this release is voluntary and that signing this form is not necessary in order to receive treatment from DOH. This release is required, however, to verify a patient's eligibility for the Medical Cannabis Program.

By signing this release I certify that I am aware that the program will verify my enrollment and caregiver 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.

This authorization will expire in one (1) year unless a different expiration date prior to one year is specified here: ___/___/___.

Signature Participant or Personal Representative: ______________________________
Print Name:____
Date: ___________________

If this form is signed by a personal representative, a witness must sign below:
Witness Signature_______________________ Date: _______________

Mailing Address:
1190 St. Francis Drive, Suite S-1300
P.O. Box 26110
Santa Fe, NM 87502

Email: medical.cannabis@state.nm.us
Website:
www.nmhealth.org/idb/medical_cannabis.shtml