There is no charge to apply for a Primary Caregiver ID card. An application that is not complete or hard to read may delay your card. Send pages with ORIGINAL signatures. The program cannot accept copies of applications. Please send all items in one envelope.

Please keep a copy of everything you send in, including a copy of the Caregiver's New Mexico ID.

Every year the patient will need to send a Patient Application completed by the patient, and the patient’s medical provider to keep the Medical Cannabis Program card active, however you do not need to submit the Caregiver Application every year. The caregiver application should be submitted every three years with the patient application.

### Checklist and Instructions for Primary Caregiver Applications

**This application is for the Primary Caregivers of new and current patients. Please use the checklist to be sure you have everything you need for your application.**

- [ ] Completed “Patient Application” for the patient who needs a Primary Caregiver (unless the person is already a patient).
- [ ] Completed “Primary Caregiver and Patient Information Form” (Page 1).
  - Make sure your form is complete and all the information is correct.
  - **NOTE:** Your mailing address is where you want your card sent.
- [ ] 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 “Parental Consent Form for Minors” (Page 3).
- [ ] Both you and the patient need to sign and date the form. These must be ORIGINAL signatures.
  - If the patient is 18 years old or older and the form is signed by someone else, send legal papers that allow this (e.g.: Medical Power of Attorney or guardianship papers).
  - 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.
- [ ] Clear copy of caregiver’s valid New Mexico Driver’s License or New Mexico photo ID.
  - Temporary New Mexico Driver’s License and photo IDs are acceptable.

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

Revised 02-22-2022
Medical Cannabis Program

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

Primary Caregiver Information

First Name: ___________________________ Last Name: ___________________________

Middle Name: ________________________ Date of Birth (MM/DD/YYYY): ________________________

Phone Number: ________________________ Email: ________________________

Mailing Address: ____________________________________________________________

City: ___________________________ Zip Code: ___________________________

New Mexico County of Residence: ___________________________________________

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: ___________________________ Last Name: ___________________________

Middle Name: ________________________ Date of Birth (MM/DD/YYYY): ________________________

Phone Number: ________________________ Email: ________________________

Mailing Address: ____________________________________________________________

City: ___________________________ Zip Code: ___________________________

New Mexico County of Residence: ___________________________________________

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).
Primary Caregiver Medical Certification Form

TO BE COMPLETED BY A MEDICAL PROVIDER

Patient’s Full Name: ___________________________ Date of Birth (MM/DD/YYYY): ________________

Provider Name: ___________________________

NM Controlled Substance: ___________________________

Office Mailing Address: ___________________________

City: ___________________________ State: NM Zip: ________________

Provider Telephone Number: ___________________________

Patient’s Qualifying Condition: ___________________________

Medical Provider’s email Address: ___________________________

Medical justification for the patient’s need for a Primary Caregiver:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

By signing below, you are certifying that the patient needs 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)

Please include the Caregiver’s NM State ID and for Minors a copy of the Birth Certificate.

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

<table>
<thead>
<tr>
<th>Mail To: Department of Health</th>
<th>Drop Off To: Department of Health</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Santa Fe, NM 87502-6110</td>
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</tr>
</tbody>
</table>

Program Staff Signature: ___________________________ Date: ___________________________

☐  Approved  ☐  Denied  ☐  Additional notes in BioTrack
Parental Consent Form for Minors

ONLY REQUIRED FOR APPLICANTS UNDER 18 YEARS OF AGE

I, _________________________________, following New Mexico State Law (the Lynn & Erin Compassionate Use Act and the NM Administrative Code 7.34.3), certify the following:

• I am the Parent (or Legal Guardian) of _______________________________.

(Parent or Guardian’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.

• 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 or Guardian’s Signature ___________________________ Date _____________________________
(Please print form - then sign)

***Please include a copy of the minors Birth Certificate. If this form is not signed by a parent listed on the Birth Certificate but is signed by the guardian, please provide documents clearly showing that the Caregiver has the authority to make medical decisions on behalf of the minor.*****