NEW MEXICO DEPARTMENT OF HEALTH

Medical Cannabis Program

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

Application for a Personal Production License

Medical Cannabis can only be grown by an approved patient or their caregiver.

Please give DETAILED answers to all the questions and attach more pages if needed. An application that is not complete or hard to read may delay your Personal Production License.

The Personal Production License (PPL) will expire on the date printed on the PPL card. You must reapply every year to keep your PPL license current. There is a $30 fee to apply for a PPL each year.

The Medical Cannabis Program will check the information in this application and other documents that are sent in. This may include a visit to the grow location.

IMPORTANT: If you rent, lease, live in subsidized housing, or live on tribal/federal land, please be aware that you may not be allowed to grow medical cannabis on the property.

Send ORIGINAL pages. The program cannot accept photocopies, faxes or electronic copies at this time. Please keep a copy of everything you send in and be sure ALL pages are complete before sending.

If you are authorizing a caregiver to apply for the PPL, both the caregiver **and** the patient need to sign the application. **Please note, a PPL can only be issued to either the patient OR the caregiver.**

If you purchase seeds, clones, or plants from a Licensed Non-Profit Producer, you will need to have your PPL card with you.

Patient Information

First Name:_____ **Last Name**: _____

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

Date of Birth (MM/DD/YYYY):_____ Phone: _____

Email Address: _____

Caregiver Information (Fill in only if caregiver will hold the PPL license)

First Name:_____ **Last Name**: _____

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

Date of Birth (MM/DD/YYYY):_____ Phone: _____

Email Address: _____

Address Information (provide mailing address for PPL holder and grow address)

Mailing Address: _____

City: _____

County: _____

Zip: _____

Grow Address: _____

City: _____

County: _____

Zip: _____

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Grow Location Information

SECTION 1: Supporting Documents - *This section must be completed and documents* sent in **every year**.*

☐ I **own** this property: include a copy of one of the documents listed below. It must include both your name **and** the address of the grow.

- Property Tax Record
- County Assessor's Record
- Homeowner's Insurance Policy (current)
- Mortgage Statement (within last 30 days)

*If you do not have the documents listed, please call 505-827-2321

☐ I am **not the owner** of this property: You must have the "Landlord or Property Owner Permission Statement" on page 5 completed. Be sure to send this with your application.

SECTION 2: Location Description.

Where do you plan to grow? ☐ Inside ☐ Outside ☐ Both

Describe the grow location. Tell us if the grow will be in a room or closet in the house, a separate building, a greenhouse, a garden, etc. and give a short description of the area around it. Use more pages, if needed.

_____

_____

_____

_____

_____

SECTION 3: Number of Licenses.

Please answer the questions below.

How many Personal Production Licenses (grow licenses) will be at this location? _____
NOTE: Only two Personal Production Licenses are allowed at one location.

List the name and date of birth of any other patient or caregiver who holds a Personal Production License at the same grow location:

_____

If there will be more than one grow, how will you know which plants belong to each patient?

_____

_____

_____

SECTION 4: Security of Location

The Medical Cannabis Program takes security very seriously. We must be sure your grow location is secure so please answer **all** the questions below. You can attach maps, pictures or drawings, but we still need all the questions answered.

How will you make sure your plants cannot be seen from any public areas (e.g. through windows or over fences)? Use more pages, if needed.

_____

_____

_____

What items will be used for security (e.g. cameras, locks, or fences) and how will they be used to protect your grow area? How will you make sure no one (especially minors) can get to the plants or into any storage area(s) in your house (except a licensed caregiver). Use more pages, if needed.

_____

_____

_____

Payment - Choose one of the following:

- ☐ My payment of a $30 non-refundable check or money order is included.
  Make check or money order payable to **Department of Health MCP**. All checks are deposited upon receipt. ***If you are paying the fee***, there is no need to send proof of income.
  Check or Money Order Number: _____
- ☐ My household is at or below 200% the Federal Poverty Level (FPL)* and I cannot pay the $30 fee.
  If you cannot pay the fee, complete following:
  Total household income:_____The number of people who live with you: _____
  Your initials: _____Date: _____ We may ask for additional information to verify proof of income.

* FPL information is available on-line at websites like http://familiesusa.org/product/federal-poverty-guidelines.

NMDOH use ONLY: Payment or income information received by: _____

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All the information above is complete and correct. I will follow the limits and restrictions on my right to use, have, and grow medical cannabis that are in the laws of New Mexico (the Lynn and Erin Compassionate Use Act and in New Mexico Administrative Code 7.34.4). These laws are on the program's website at: nmhealth.org/go/mcp.

Applicant Signature:_____ Date: _____
(Please print form - then sign)

If you are the primary caregiver of a medical cannabis patient and you are applying for the PPL, the patient **must** also sign below.

Patient Signature:_____ Date: _____
(Please print form - then sign)

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

NMDOH USE

Program Staff Signature:_____Date: _____

☐ Approved ☐ Denied ☐ Request for Information Sent ☐ Additional notes in BioTrack

Property Owner or Landlord Permission Statement*

Date: _____

Dear Medical Cannabis Program Staff:

I _____ am the property owner of _____.
(Property Owner's Name) (Property Address)

I give permission to _____ to grow medical cannabis on this
(Renter's or Relative's Name)

property as allowed by New Mexico State Law (NMAC 7.34.4.18).

Sincerely,

_____
(Property Owner's Name)

* Necessary for any PPL application if the applicant does not own the property where they plan to grow. Disregard this form if you own the property where you plan to grow medical cannabis.