

Internal Checklist (Both are Required)

- Legible copy of valid NMDOH MCP Patient ID card and photo ID
- Completed, signed and approved packet

**Mother Earth Herbs
New Patient Registration Form**



Patient Information

First and Last Name: _____

NM MCP Card No: _____

Do you have a PPL? Y / N

Home address: _____

City/State/Zip Code: _____

Mobile Phone number: _____ Carrier _____

Email: _____

Birthday: _____ How did you hear about us? _____

Caregiver Information

| If you are a registered caregiver, please fill out the information below | |
|--|-----------------------|
| Caregiver First and Last Name: | _____ |
| Caregiver NM MCP Card No: | _____ |
| Caregiver Home Address: | _____ |
| City | _____ Zip Code: _____ |
| Caregiver Email: | _____ Phone: _____ |

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Enrollment Agreement

I agree to allow Mother Earth Herbs to share and verify information with the New Mexico Department of Health. *

I understand that any form of medical cannabis purchased from Mother Earth Herbs, is for my personal medicinal requirements only. I will not sell or share with any other person. *

I understand that neither Mother Earth Herbs or New Mexico Department of Health can protect me from the federal criminal prosecution of medical cannabis use or possession. *

I AM A QUALIFIED NEW MEXICO MEDICAL CANNABIS PATIENT in good standing and licensed to use medical cannabis. *

I AGREE TO NOTIFY Mother Earth Herbs IMMEDIATELY if my license status changes and additionally I agree to abide by the limitations of the use and possession of medical cannabis. *

I HAVE READ AND UNDERSTAND THE LYNN AND ERIN COMPASSIONATE USE ACT and I understand the risks of using cannabis and agree to use it responsibly. *

I RELEASE AND INDEMNIFY Mother Earth Herbs its Board of Directors and employees from any liability arising from my use or possession of medical cannabis including, physical effects and criminal prosecution. *

I UNDERSTAND THAT I AM NOT PROTECTED from federal prosecution. *

I AGREE NOT TO TRANSPORT MEDICAL CANNABIS across the New Mexico border. *

I UNDERSTAND THAT MOTHER EARTH HERBS WILL KEEP ALL MY PERSONAL INFORMATION CONFIDENTIAL and will only share information with the Department of Health. *

I consent and agree to the terms in the HIPAA INFORMATION and any subsequent changes in Mother Earth Herbs' policy. *

Signature _____

Date _____