LNPP Identification Card Request

NEW MEXICO DEPARTMENT OF HEALTH

Please print clearly - This form will be returned to the employer without further processing if any portion is left blank or if required forms are not provided.

THIS FORM MUST BE COMPLETED IN FULL BY THE LNPP AND APPLICANT

Applicant First Name: _____ Last: _____ MI: _____
Employee Date of Birth: (for verification in case of duplicate names) _____/_____/_____ (MM/DD/YYYY)
Date of Hire: _____/_____/_____ (MM/DD/YYYY)
Status of Applicant: _____Paid Employee _____Board Member _____Volunteer _____3rd Party Entity
Position/Job Duty: (Board member, sales, CDP, testing, etc.) _____
LNPP Name: _____
LNPP Representative Completing Application: _____
Mailing Address of LNPP: _____
Contact Number: _____

Application Checklist

Please ensure all items are included when submitting application

- ☐ **Photocopy of Identification**
- ☐ **State Criminal Background Check**
- ☐ **Nationwide Criminal Background Check**
- ☐ **HIPAA Certification**
- ☐ **This is a replacement LNPP ID card**

☐ **If the applicant represents, consults, works, volunteers, or contracts with another LNPP, list the name of each LNPP below:**

_____
_____
_____
_____
_____

By signing below you accept that the LNPP Identification Card is the property of the Medical Cannabis Program and will be immediately returned to the MCP upon separation from the LNPP.

Applicant Signature: _____ **Date:** _____

Authorized LNPP Representative: _____ **Date:** _____

NMDOH USE ONLY

Review Date: _____

☐ Approved ☐ Not Approved

Program Coordinator/Manager Signature: _____ Date: _____

Revised: 10/22/2013