

New Mexico Department of Health
Proposed Adoption of the New Rule 7.35.3 NMAC Patients,
Certifying Clinicians, Practitioners, Facilitators, Healing Centers,
Other Approved Locations, and Educational Programs
Hearing Date: October 2nd, 2026

LIST OF EXHIBITS

1.	<u>Proposed New Rule</u> 7.35.3 NMAC Patients, Certifying Clinicians, Practitioners, Facilitators, Healing Centers, Other Approved Locations, and Educational Programs
2.	<u>Proposed Amendments</u> 7.35.2 NMAC Medical Psilocybin Producer and Laboratory Requirements
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6.	Letter Appointing Hearing Officer
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8.	Public Comments
	8.A. Public Comment – I. Dunn
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TITLE 7 HEALTH
CHAPTER 35 MEDICAL PSILOCYBIN
PART 3 PATIENTS, CERTIFYING CLINICIANS, PRACTITIONERS, FACILITATORS,
HEALING CENTERS, OTHER APPROVED LOCATIONS, AND EDUCATIONAL PROGRAMS

7.35.3.1 ISSUING AGENCY: New Mexico department of health.
 [7.35.3.1 NMAC - N, xx/xx/2026]

7.35.3.2 SCOPE: This rule applies to all patients, practitioners, clinicians, facilitators, healing centers and other approved locations, and educational programs who participate or seek to participate in the New Mexico medical psilocybin program.
 [7.35.3.2 NMAC - N, xx/xx/2026]

7.35.3.3 STATUTORY AUTHORITY: This rule is promulgated pursuant to the following statutory authorities: the New Mexico Department of Health Act, Subsection E of Section 9-7-6 NMSA 1978; and the Medical Psilocybin Act, Section 26-2D-7, NMSA 1978.
 [7.35.3.3 NMAC - N, xx/xx/2026]

7.35.3.4 DURATION: Permanent.
 [7.35.3.4 NMAC - N, xx/xx/2026]

7.35.3.5 EFFECTIVE DATE: xx/xx, 2026, unless a later date is cited at the end of a section.
 [7.35.3.5 NMAC - N, xx/xx/2026]

7.35.3.6 OBJECTIVE: The objective of this rule is to adopt rules governing the enrollment of qualified patients and the certification of certifying clinicians, practitioners, facilitators, educational programs, and approved locations, in accordance with the Medical Psilocybin Act at Sections 26-2D-1 through -11, NMSA 1978.
 [7.35.3.6 NMAC - N, xx/xx/2026]

7.35.3.7 DEFINITIONS: The definitions in 7.35.2.7 NMAC apply to this part.
 [7.35.3.7 NMAC - N, xx/xx/2026]

7.35.3.8 PATIENT ENROLLMENT APPLICATION PROCESS: A completed patient application shall be submitted by a patient and the patient's certifying clinician using the electronic system designated by the department, in accordance with the following:

A. Patient submittal requirements: An applicant for enrollment as a qualified patient in the medical psilocybin program shall submit the following information to the department:

- (1) Applicant's legal name, address, telephone number, and e-mail address;
- (2) Applicant's date of birth;
- (3) Name of the applicant's certifying clinician;
- (4) A legible copy of the patient's driver's license or comparable photo identification card;
- (5) The applicant's signature and date;
- (6) A signed consent for release of medical information related to the patient's qualifying medical condition, on a form provided by the medical psilocybin program;
- (7) Completed affirmation form, which shall include but not be limited to attestations that:
 - (a) The applicant has a qualifying diagnosis;
 - (b) The applicant provided information to the certifying clinician that was, to the best of the applicant's knowledge, true and correct;
 - (c) The applicant has discussed with their certifying clinician the risks and benefits of medical psilocybin usage, and that the applicant understands those risks; and
- (8) Such additional information and documentation as the department may reasonably require.

B. Certifying clinician submittal requirements: A certifying clinician shall submit the following information to the department in support of a patient's application for enrollment in the medical psilocybin program:

- (1) Name of applicant for patient enrollment;
- (2) Name, address, telephone number, and e-mail address of the certifying clinician;

(3) Clinical licensure of the certifying clinician, including controlled substance number;
 (4) The patient's qualifying diagnosis, the date of diagnosis or date of confirmation of the diagnosis;
 (5) Documentation of diagnosis of qualifying condition by a certifying clinician;
 (6) If the in-person exam was conducted by another clinician: the name and contact information for the clinician who performed the exam;
 (7) Information required for patient participation in the Equity and Access Fund (as applicable);
 (8) Completed affirmation forms, which shall include but not be limited to attestations that:
 (a) The applicant has a qualifying diagnosis;
 (b) The certifying clinician has discussed with the applicant the risks and benefits of medical psilocybin usage;
 (c) The certifying clinician has evaluated the medical appropriateness of the patient's proposed enrollment in the New Mexico psilocybin program, and that, in the clinician's professional opinion, the potential health benefits of the medical use of psilocybin would likely outweigh health risks for the patient; and
 (i) the certifying clinician has conducted an in-person examination of the patient within the previous six months;
 (ii) the certifying clinician has conducted a patient evaluation via telemedicine and has reviewed the medical records pertaining to the diagnosis of a qualifying condition and has confirmed the medical records of the diagnosis are from a clinician who has conducted an in-person examination of the patient within the previous six months; or
 (iii) the certifying clinician has conducted a patient evaluation via telemedicine and has had a formal consultation with a clinician who has conducted an in-person exam with the patient within the previous six months; and
 (9) Such additional information and documentation as the department may reasonably require.

C. Once the department has received a completed application, it will review the application and render a decision within 30 calendar days.

(1) The department will notify the patient of the approval or denial of the application through the electronic system designated by the department.

(2) The department may verify information contained in an application by reference to information submitted by a certifying clinician, and by otherwise contacting a certifying clinician to obtain information and review medical records.

D. A person whose application for patient enrollment is denied for failure to complete an application or failure to meet a submittal requirement of this rule may request a record review to be conducted by the department, in accordance with this rule.

E. A qualified patient's enrollment in the medical psilocybin program shall expire two years after the initial date of enrollment. If additional treatment is needed, a qualified patient may re-enroll if their enrollment has expired.

[7.35.3.8 NMAC - N, xx/xx/2026]

7.35.3.9 CERTIFYING CLINICIAN, PRACTITIONER, AND FACILITATOR APPLICATION

PROCESS: An individual may apply for certification as a certifying clinician, practitioner, or facilitator in the medical psilocybin program in accordance with this rule. The applicant shall submit a completed application packet through the electronic system designated by the department.

A. Approval and denial; certification period:

(1) Once the department has received a completed application, it will review the application and render a decision within 30 calendar days.

(2) The department will notify the applicant of the approval or denial of the application through the electronic system designated by the department.

(3) If the application is approved, the certification shall be effective on the date of notice and shall be valid for two years.

(4) If the department denies an application, the department shall provide notice of the denial within 30 calendar days in accordance with this rule.

(5) If the application is denied, the applicant may re-apply within six months.

(6) An applicant who is denied a second time may not re-apply for six months from the denial.

(7) An applicant whose application is denied may appeal the denial in accordance with this rule.

B. Renewal of certification; submittal deadline: Applicants for renewal of certification shall submit a completed renewal application packet through the electronic system designated by the department no more than 60 calendar days and no less than 30 calendar days prior to the expiration of their current certification.

C. General application requirements: An applicant for certification as a certifying clinician, practitioner, or facilitator shall submit the following as part of their completed application packet, using the electronic system designated by the department:

- (1) Applicant's legal name, address, telephone number, and e-mail address;
- (2) A legible copy of the applicant's driver's license or comparable photo identification card;
- (3) Documentation that the applicant has completed the applicable educational requirements and practicum requirements;
- (4) Documentation of satisfaction of continuing education requirements (if applying for renewal);
- (5) Completed affirmation and consent forms:
 - (a) Consent to publication of contact information (name, phone number, e-mail address);
 - (b) Affirmation that all of the information submitted is true and accurate; and
 - (c) Attestation that the applicant is not registered in any jurisdiction as a sex offender;
- (6) The applicant's signature and date of application submittal.

D. Certifying clinician application requirements: An applicant for certification as a certifying clinician shall additionally submit the following, using the electronic system designated by the department:

- (1) Documentation of current professional license to practice in New Mexico and diagnose the qualifying conditions (e.g., MD, NP);
- (2) NM controlled substance number;
- (4) Documentation of HIPAA certification completed within the preceding two years;
- (5) Completed W-9 form; and
- (6) Such additional information and documentation as the department may reasonably require.

E. Practitioner application requirements: An applicant for certification as a practitioner shall additionally submit the following, using the electronic system designated by the department:

- (1) Documentation of current professional license to practice therapy, counseling, or behavioral services in New Mexico (e.g., PSY, LSW, LCSW);
- (2) Documentation of completion of the department-approved practicum requirements;
- (3) Documentation of current:
 - (a) Basic life support (BLS) certification;
 - (b) Both cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) certification; or
 - (c) Licensure as a New Mexico emergency medical technician (e.g., EMT-basic, EMT-intermediate, EMT-paramedic);
- (4) Documentation of HIPAA certification completed within the preceding two years;
- (5) Completed W-9 form; and
- (6) Such additional information and documentation as the department may reasonably require.

F. Facilitator application requirements: An applicant for certification as a facilitator shall additionally submit the following, using the electronic system designated by the department:

- (1) Documentation of completion of the department-approved practicum requirements;
- (2) Documentation of current:
 - (a) Basic life support (BLS) certification;
 - (b) Both cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) certification; or
 - (c) Licensure as a New Mexico emergency medical technician (e.g., EMT-basic, EMT-intermediate, EMT-paramedic);

- (3) Documentation of HIPAA certification completed within the preceding two years;
- (4) Completed W-9 form; and
- (5) Such additional information and documentation as the department may reasonably

require.

[7.35.3.9 NMAC - N, xx/xx/2026]

7.35.3.10 APPLICATION PROCESS FOR CERTIFICATION AS A CERTIFYING CLINICIAN, PRACTITIONER, OR FACILITATOR BASED ON EDUCATIONAL PROGRAMS FROM OTHER JURISDICTIONS:

A. List of department-approved psilocybin educational programs from other jurisdictions:

(1) The department shall maintain a list of psilocybin educational programs from other jurisdictions that have been identified by the department as being equivalent to the didactic educational requirements applicable for New Mexico certification, and that may be utilized as a basis for certification pursuant to this rule section.

(2) Educational programs shall be added to the list when an application for certification as a certifying clinician, practitioner, or facilitator is submitted and approved based on the applicant's completion of the out-of-state educational program.

(3) Such educational programs shall include both government-approved psilocybin educational programs from other jurisdictions (including but not limited to psilocybin educational programs approved by the states of Oregon and Colorado as of December 31, 2027), and psilocybin educational programs developed in collaboration with higher institutes of education or government-approved psychedelic research studies.

(4) Educational programs that are added to the department list of approved psilocybin educational programs from other jurisdictions shall remain on the list for two years, except that:

(a) Educational programs that have been added to the department approved list will be removed if they lose certification, approval, or licensure from their issuing jurisdiction; and

(b) An educational program from the department list of approved psilocybin educational programs from other jurisdictions may be removed if the department determines that the didactic requirements of the educational program are no longer equivalent to those applicable for New Mexico certification.

(5) Consistent with this rule, educational programs that are included on the list of approved educational programs from other jurisdictions do not hold certification under this rule, and shall not be entitled to an administrative appeal in the event that the educational program is removed from the list.

B. Applications for certification based on a psilocybin educational program from another jurisdiction: An individual may apply for certification to be either a certifying clinician, practitioner, or facilitator in New Mexico on the basis of having completed a psilocybin educational program from another jurisdiction. An applicant for such certification shall submit the following, using the electronic system designated by the department:

(1) All of the information and documentation required for a certifying clinician, practitioner, or facilitator under the preceding section of this rule;

(2) Documentation of either:

(a) Completion of a government approved psilocybin educational program from another jurisdiction, which shall include:

(i) Documentation that the curriculum of the educational program is equivalent to the didactic educational requirements applicable for New Mexico certification; and

(ii) For all applications received on or after January 1, 2028, documentation of a third-party evaluation of the curriculum demonstrating such equivalency;

(b) Completion of a psilocybin educational program from another jurisdiction that is developed in collaboration with higher education institutions or government-approved psychedelic research studies, which shall include:

(i) Documentation that the curriculum of the educational program is equivalent to the didactic educational requirements applicable for New Mexico certification, and

(ii) For all applications received on or after January 1, 2028, documentation of a third-party evaluation of the curriculum demonstrating such equivalency; or

(c) Completion of an educational program that is currently included on the list of department-approved psilocybin educational programs from other jurisdictions.

(3) Documentation of completion of the New Mexico required educational module; and

(4) Documentation of completion of practicum or practice with the minimum number of patients and hours as required by this rule.

C. Application approval and denial; certification period: If the application is approved, the certification shall be effective on the date of notice and shall be valid for two years. If the department denies an application, the department shall provide notice of the denial in accordance with this rule. If the application is denied, the applicant may re-apply within six months. An applicant who is denied a second time may not re-apply for six months from the denial. An applicant whose application is denied may appeal the denial in accordance with this rule.

D. Waiver of practicum requirements:

(1) An applicant for certification as a practitioner or facilitator on the basis of an educational program from another jurisdiction and whose application is received by the department by December 31, 2027, shall not be required to complete the full practicum hours required by this rule, but shall demonstrate completion of at least 40 hours of contact time with a minimum of two separate individual sessions and two separate group sessions for preparation, administration, and integrative therapy with psilocybin treatment.

(2) The department may otherwise waive, temporarily suspend, or reduce the practicum requirements for individuals applying on the basis of having completed a psilocybin educational program from another jurisdiction, in order to facilitate the certifying of individuals trained by other governmental approved programs to build the initial infrastructure of the program.

[7.35.3.10 NMAC - N, xx/xx/2026]

7.35.3.11 APPLICATION PROCESS FOR HEALING CENTERS AND OTHER APPROVED LOCATIONS:

A. Applications for healing centers: An applicant seeking certification as a healing center shall submit a complete application through the electronic system designated by the department. A complete application shall include, at minimum, the following:

- (1) Applicant's legal name, address, telephone number, and e-mail address;
- (2) Names and contact information of primary contact person(s) and any affiliated practitioners or facilitators;
- (3) An organizational chart depicting the applicant's governance and operational structure;
- (4) Proof of registration with the New Mexico secretary of state;
- (5) Proof of registration with the New Mexico taxation and revenue department;
- (6) Copies of any required business licenses issued by applicable New Mexico cities or counties;
- (7) A certificate of occupancy for each location in New Mexico where the program will conduct operations;
- (8) Proof of ownership of any property on which medical psilocybin administration sessions will be conducted, or a signed, written statement from the owner of such property acknowledging that the owner understands that persons will be participating in the medical psilocybin program on the premises, and what those persons are authorized to do within the terms of their certification;
- (9) Proof of compliance with applicable laws and regulations governing accessibility for individuals with disabilities;
- (10) A list of all owners or members of the board of directors, including corresponding contact information;
- (11) Primary program contact information, including name, physical address, telephone number, and e-mail address;
- (12) Record retention plan;
- (13) Plan for maintaining confidentiality of patient information;
- (14) A safety and emergency response plan appropriate to the location's operational settings, to include adverse health event response and reporting;
- (15) A written outline of the location's complaint and grievance procedures available to patients;
- (16) Plan for secured storage for medical psilocybin;
- (17) Plans for wastage of any unused medical psilocybin;
- (18) Plan demonstrating how patient confidentiality will be maintained within the healing center;
- (19) Plan for transparency and disclosure of fees for patients;
- (20) Proof that the location has a functioning communication device which can reliably reach emergency medical services;

(21) For a location that intends to conduct administration sessions in an outdoor or natural environment:

- (a) A detailed description of the outdoor administration area, including identification of safe entrances and exits, and verification that the area is free from hazards;
- (b) An emergency safety and response plan; and
- (c) Proof that emergency medical services can reliably be contacted from, and respond to, the location at which medical psilocybin administration sessions will occur.

(22) A list of all other employees of the organization, including their legal names;

(23) Completed affirmation and consent forms:

- (a) Consent to publication of contact information (name, phone number, e-mail address, website), if certified;
- (b) Affirmation that all of the information submitted is true and accurate; and
- (c) Attestation that no persons associated with the applicant are registered in any jurisdiction as a sex offender;

(24) Signature of authorized representative and date of application submittal; and

(25) Such additional information and documentation as the department may reasonably require.

B. Applications for other approved locations: A practitioner or facilitator may apply for temporary department certification of an “other approved location”. Other approved locations are physical locations at which medical psilocybin is intended to be consumed, that are not locations of healing centers. Such locations may be certified if a qualified patient is unable to be physically transported to a healing center, for other reasons of medical necessity, for purposes of improving patient access in rural and frontier counties, or to enable treatment to occur in a natural environment setting. Such locations may include a patient’s residence, or another temporary location. An applicant who seeks certification of such a location shall submit a complete application using the electronic system designated by the department. A complete application shall include, at minimum, the following:

- (1) Address and description of the location to be utilized;
- (2) Plan for secure transportation and safe storage for medication;
- (3) Plans for wastage of any unused medicine;
- (4) A safety and emergency response plan;
- (5) Proof that the location has a functioning communication device which can reliably reach emergency medical services;
- (6) Plan for safe storage of any firearms on the premises during and after treatment sessions;
- (7) Plan demonstrating how patient confidentiality will be maintained;
- (8) A statement regarding the appropriateness of the location for treatment sessions;
- (9) Proof of ownership by the qualified patient or attending practitioner or facilitator of any property on which medical psilocybin administration sessions will be conducted, or a signed, written statement from the owner of such property acknowledging that the owner understands that persons will be participating in the medical psilocybin program on the premises, and what those persons are authorized to do within the terms of their certification;

(10) For outdoor or natural environments:

- (a) A detailed description of the administration area, including identification of safe entrances and exits, and verification that the area is free from hazards;
- (b) An emergency safety and response plan; and
- (c) Proof that emergency medical services can reliably be contacted from, and respond to, the location at which medical psilocybin administration sessions will occur;

(11) Affirmation that all of the information submitted is true and accurate;

(12) Signature of authorized representative and date of application submittal; and

(13) Such additional information and documentation as the department may reasonably require.

C. Application for renewal of certification for healing centers: An applicant seeking renewal of certification as a healing center shall submit a complete renewal application packet through the department-approved electronic system no more than 60 calendar days and no less than 30 calendar days prior to the certification’s expiration date.

D. Certification period; approval and denial: Certification of a healing center shall be effective on the date of department issuance and shall be valid for two years. Certification of other approved locations shall be effective on the date of department issuance and shall be valid for 90 calendar days. If the department denies an

application for a healing center or other approved location, the department shall provide notice of the denial within 30 calendar days in accordance with this rule. If the application is denied, the applicant may re-apply within six months. An applicant who is denied a second time may not re-apply for six months from the denial. An applicant whose application is denied may appeal the denial in accordance with this rule.
[7.35.3.11 NMAC, xx/xx/2026]

7.35.3.12 APPLICATION PROCESS FOR PSILOCYBIN EDUCATIONAL PROGRAMS:

A. Application requirements: An applicant seeking certification as a psilocybin educational program shall submit a complete application through the electronic system designated by the department. A complete application shall include, at minimum, the following:

- (1) An organizational chart depicting the applicant's governance and operational structure;
- (2) Proof of registration with the New Mexico secretary of state;
- (3) Proof of registration with the New Mexico taxation and revenue department;
- (4) Copies of any required business licenses issued by applicable New Mexico cities or counties;
- (5) A certificate of occupancy for each location in New Mexico where the program will conduct operations;
- (6) Proof of compliance with applicable laws and regulations governing accessibility for individuals with disabilities;
- (7) A list of all owners or members of the board of directors, including corresponding contact information;
- (8) Primary program contact information, including name, physical address, telephone number, and email address;
- (9) A record retention plan;
- (10) A safety and emergency response plan appropriate to the program's operational settings;
- (11) A written outline of the program's complaint and grievance procedures available to students;
- (12) A signed consent authorizing the department to publicly list the program's contact information and website, if certification is granted;
- (13) A list of all instructors, accompanied by curricula vitae or resumes demonstrating collective expertise sufficient to meet all required curriculum areas;
- (14) A copy of the curriculum to be utilized by the program, including a brief description demonstrating how the curriculum satisfies the department's curriculum requirements;
- (15) Copies of all course syllabi and a web address at which the program will publicly maintain updated syllabi for prospective students;
- (16) A plan describing how the program will ensure transparency in the disclosure of all student fees;
- (17) A plan demonstrating how the program will ensure that enrolled students complete all required components and graduate within two years of enrollment;
- (18) A signed consent authorizing the department to publicly list the curriculum and syllabi submitted with the application, if approval is granted;
- (19) A third-party evaluation report that is conducted by a qualified third-party evaluation team in accordance with this rule, and that complies with the requirements of this section;
- (20) Proof of established arrangements with healing centers or other department-approved locations for student practicum placements;
- (21) Documentation demonstrating that, no later than December 31, 2027, the program will employ at least two faculty members who hold current practitioner or facilitator certificates issued by the department;
- (23) A list of all other employees of the organization, including their legal names; and
- (24) Such additional information and documentation as the department may reasonably require.

B. Third-party evaluation reports: Applications for certification as an education program shall include a third-party evaluation report, generated in accordance with this rule, that assesses the organization and curriculum of the educational program and that demonstrates that the educational program meets requirements for medical psilocybin educational programs in New Mexico.

(1) Applications for certification as an education program that are submitted on or before December 31, 2027 may be approved without an accompanying third-party evaluation report, provided that the applicant submits the third-party evaluation by December 31, 2027. If the third-party evaluation is not submitted, the certification will be rescinded.

(2) Applications for certification as an education program that are submitted after December 31, 2027 shall include the third-party evaluation.

C. Application for renewal of educational program certification: An applicant seeking renewal of its psilocybin educational program certification shall submit a complete renewal application packet through the department-approved electronic system no more than 60 calendar days and no less than 30 calendar days prior to the certification expiration date.

D. Approval and denial; certification period: If the application is approved, the certification shall be effective on the date of notice and shall be valid for two years. If the department denies an application, the department shall provide notice of the denial in accordance with this rule. If the application is denied, the applicant may re-apply within six months. An applicant who is denied a second time may not re-apply for six months from the denial. An applicant whose application is denied may appeal the denial in accordance with this rule.

[7.35.3.12 NMAC - N, xx/xx/2026]

7.35.3.13 REQUIREMENTS AND PROHIBITIONS FOR CERTIFYING CLINICIANS, PRACTITIONERS, AND FACILITATORS:

A. Certifying clinicians; actual clinician-patient relationship required; telemedicine:

(1) In order to certify a patient, a certifying clinician must have an actual clinician-patient relationship with the patient. The certifying clinician shall conduct an in-person physical evaluation and medical clearance of the applicant or qualified patient prior to issuing a certification; or

(2) A certifying clinician may issue a patient certification on the basis of an evaluation conducted via telemedicine if one of the following conditions applies:

(i) the certifying clinician has conducted an in-person examination of the patient within the previous six months;

(ii) the certifying clinician has conducted a patient evaluation via telemedicine and has reviewed the medical records pertaining to the diagnosis of a qualifying condition and has confirmed the medical records of the diagnosis are from a clinician who has conducted an in-person examination of the patient within the previous six months; or

(iii) the certifying clinician has conducted a patient evaluation via telemedicine and has had a formal consultation with a clinician who has conducted an in-person exam with the patient within the previous six months.

B. Facilitators; scope of work: A facilitator is authorized to work alongside a practitioner during medical psilocybin services. A facilitator works under the direct supervision of a practitioner, and provides peer support to qualified patients, as well as logistical and administrative support to the practitioner and to the healing center. A facilitator shall not perform any patient care outside this scope, unless another license held by the facilitator permits it.

C. Practitioners and facilitators; submittal of patient treatment information to department: Practitioners and facilitators shall maintain the following information and submit such information to the department using the electronic system designated by the department:

(1) Dates and types of services provided to patients for evaluation and preparation sessions;

(2) Information concerning the administration of medical psilocybin to the patient, including but not limited to:

(a) Dates of administration of medical psilocybin products, and healing centers and other approved locations where medical psilocybin was administered to the patient;

(b) Unique identification numbers of medical psilocybin products administered;

(c) Dosage of medical psilocybin products administered;

(d) Dates of initial integrative sessions; and

(e) Any adverse health events; and

(3) Such additional information and documentation as the department may reasonably require.

D. Practitioners and facilitators; psilocybin product information; notification to patients of failed test results:

(1) A practitioner or facilitator who administers a psilocybin product to a qualified patient shall, upon request, make reasonable efforts to provide a translation of the psilocybin product information document in languages other than English and in an accessible format.

(2) A practitioner or facilitator who administers to a patient a psilocybin product that is determined by a producer to have come from a psilocybin lot that failed required testing shall timely forward the producer's notification of the failed test to the qualified patient who consumed the product.

E. Certifying clinicians, practitioners, and facilitators; prohibition against certifying or treating certain relatives: A certifying clinician, practitioner, or facilitator shall not certify or treat a patient who is related to the certifying clinician, practitioner, or facilitator within the second degree of consanguinity or the first degree of affinity. This includes a spouse, child, stepchild, parent, stepparent, sibling, grandparent, mother-in-law, father-in-law, son-in law, or daughter-in-law.

F. Certifying clinicians, practitioners, and facilitators; prohibition against intoxicants: A certifying clinician, practitioner, or facilitator shall not consume or otherwise be under the influence of psilocybin or any other intoxicant when providing services to a patient.

G. Record access: Certifying clinicians, practitioners, and facilitators shall timely provide the department access to records upon the department's request.

[7.35.3.13 NMAC, xx/xx/2026]

7.35.3.14 AUTHORIZED POSSESSION, PURCHASE, OR SALE OF MEDICAL PSILOCYBIN BY PRACTITIONERS, FACILITATORS, HEALING CENTER OWNERS AND EMPLOYEES; CHAIN OF CUSTODY: Certification of a practitioner, facilitator, or healing center shall enable practitioners, facilitators, and owners and employees of healing centers to do the following, in accordance with medical psilocybin program rules:

(A) Practitioners: Practitioners may purchase and possess medical psilocybin products obtained from permitted producers, and may sell or otherwise provide medical psilocybin products to qualified patients during administration sessions conducted at a healing center location or other approved location. A practitioner may only sell or otherwise provide psilocybin products that are obtained from permitted producers.

(B) Facilitators: Facilitators may possess medical psilocybin products, for the purpose of providing those products to qualified patients in administration sessions conducted at healing centers and other approved locations.

(C) Healing centers: Owners and employees of healing centers who are registered with the department may purchase medical psilocybin products from permitted producers, may possess medical psilocybin products, and may sell or otherwise administer those products to qualified patients in administration sessions conducted at the healing center or other approved locations, provided that such individuals are also designated to engage in each activity by the healing center. A healing center may only sell or otherwise provide psilocybin products that are obtained from permitted producers.

(D) Chain of custody; documentation: A practitioner, facilitator, or healing center owner or employee who obtains or transfers medical psilocybin shall generate and submit a chain of custody form through the electronic system designated by the department, unless the chain of custody form is otherwise generated and submitted by a producer, in which case the person who receives the psilocybin shall verify that the psilocybin is accurately reflected in the system. A practitioner, facilitator, or healing center owner or employee who obtains or transports psilocybin shall be prepared to show proper identification, including an employee badge, driver's license, vehicle registration and proof of insurance, and the appropriate chain of custody form to law enforcement and the department when requested.

[7.35.3.14 NMAC, xx/xx/2026]

7.35.3.15 PSILOCYBIN EDUCATIONAL PROGRAMS; REQUIRED REPORTING AND CURRICULUM APPROVAL:

A. Review and approval of psilocybin educational program curriculum: The department shall review and evaluate the proposed curriculum, both for an initial application for psilocybin educational program certification and subsequent modifications to an approved curriculum, and shall determine whether to approve or deny the curriculum. The department may deny a proposed curriculum if:

- (1) It does not meet the overall minimum hour requirements;
- (2) It does not meet the specific requirements for each module;
- (3) If the materials present incorrect or outdated information, or information that poses a substantial threat to public health or safety;

(4) If the proposed curriculum does not clearly outline how the required topics will be covered in sufficient depth for students to understand them; or

(5) If the department otherwise determines that the curriculum fails to meet the educational objectives of this rule.

B. Required reporting of updates: A department-certified psilocybin educational program shall notify the department, through the electronic system designated by the department, of any of the following changes, and shall not implement the change until written approval is issued by the department:

(1) Any revision to the program's curriculum; revised curricula shall be submitted to the department for review and may not be implemented until the department grants approval;

(2) Any change in ownership, including changes in controlling interest or organizational structure;

(3) Any change in physical locations utilized for instruction or educational activities;

(4) Any modification, termination, or addition of practicum site agreements; and

(5) Any change in instructional or other staff, including submission of curricula vitae or resumes for all newly added instructors.

C. Psilocybin educational program curriculum approval process: Applicants shall submit a complete application packet for curriculum approval through the electronic system designated by the department. The department shall notify the applicant within 60 calendar days, through the department-approved electronic system, of whether the application is approved or denied. If approved, the approval shall take effect on the date of the notice and shall remain valid for two years. If denied, the department shall issue notice through the department-approved electronic system stating the basis for the denial. An applicant whose application has been denied may resubmit a corrected application within six months. No applicant may resubmit an application more than two times following an initial denial. An applicant may appeal a denial in accordance with the appeals process established in this rule.

[7.35.3.15 NMAC - N, xx/xx/2026]

7.35.3.16 REQUIREMENTS FOR THIRD-PARTY EVALUATORS OF EDUCATIONAL PROGRAMS:

A. General requirements: A psilocybin educational program shall engage a qualified third-party evaluation team to conduct the evaluations required under this rule. The evaluation team shall consist of no fewer than three individuals who collectively meet all competency requirements set forth in this section.

B. Minimum qualifications: Each evaluator shall possess at least three years of professional experience in one or more of the following fields, and the evaluation team as a whole shall demonstrate expertise covering all listed domains:

(1) Psilocybin therapy practice, supported by a master's or doctoral degree in counseling, therapy, social work, public health, behavioral health, or a closely related field;

(2) Medical and research practice, supported by a master's or doctoral degree in medicine, pharmacy, nursing, or another related clinical or scientific field; and

(3) Educational curriculum development and evaluation, supported by a master's or doctoral degree in education, educational psychology, or a closely related field.

C. Conflict of -interest prohibitions:

(1) All evaluators shall be free from actual or perceived conflicts of interest regarding the organization or curriculum under review.

(2) The following conflicts, at minimum, shall disqualify an individual from serving as an evaluator:

(a) Participation in the design, development, or teaching of the curriculum being evaluated; or

(b) Holding a financial interest in, receiving compensation from, or serving in any governance or advisory capacity with the program or organization being evaluated.

D. Confidentiality and impartiality: Prior to initiating evaluation activities, each evaluator shall sign a confidentiality and impartiality agreement affirming their obligation to maintain confidentiality, avoid bias, and act independently in carrying out evaluation responsibilities.

E. Evaluation report requirements: The evaluation team shall prepare a written evaluation report and shall submit the report simultaneously to both the psilocybin educational program and the department. The report shall include, at a minimum:

- (1) A description of each evaluator's professional qualifications and experience relevant to the required evaluation domains;
 - (2) Copies of all signed conflict of interest, confidentiality, and impartiality agreements;
 - (3) An assessment of the reliability, validity, and fidelity of implementation of the curriculum;
 - (4) An assessment of the reliability, validity, and fidelity of implementation of student competency evaluations, including examinations, assessments, and instructor observational feedback;
 - (5) An assessment of student feedback processes and a summary of the feedback;
 - (6) Recommendations for corrective actions or improvements, where applicable;
 - (7) Performance evaluations of all faculty members participating in the program; and
 - (8) A review and evaluation of any reported student grievances related to program instruction, curriculum implementation, or student assessment processes.
- [7.35.3.16 NMAC - N, xx/xx/2026]

7.35.3.17 EDUCATIONAL PROGRAMS; MENTORING REQUIREMENTS; RECORD-KEEPING:

A. All educational programs shall provide each practitioner and facilitator student with a minimum of 10 hours of mentoring sessions after graduation and after practicum hours are completed. The purpose of the mentoring sessions is to allow new graduates to consult with the educational program faculty regarding cases, patients, situations, and how they handle them. These mentoring sessions may not have additional associated charges beyond the cost of the educational program itself. The 10 hours are valid for up to 12 months after practicum hours are completed. If students request more than 10 hours of mentoring sessions, this will be at the purview of the educational program and may have an additional associated cost.

B. Educational programs shall offer an option for a student to complete the evaluation for each educational module (not including the New Mexico module) without attending the lessons or classes for the module. The cost to complete the evaluation for each module shall not be greater than one-fourth of the normal price of each of the educational modules. If the student receives a passing grade for a module evaluation, they will have been considered to have completed the module; and if a student does not receive a passing grade for a module evaluation, they will not have completed the module. The educational program may at its discretion allow students to re-take the evaluation without attending the lessons or classes for the modules. Students who utilize this option shall complete all other requirements for the educational program, including the New Mexico module, certifications, simulated patient, and practicum requirements to graduate from the educational program.

C. Educational programs shall maintain the following records for a minimum of five years, and as required by applicable law:

- (1) All course syllabi; and
- (2) Enrollment records, including but not limited to the:
 - (a) Name of each student;
 - (b) Date of start and completion for each student;
 - (c) Examination results and transcripts for each student;
 - (d) Dates, locations, and number of patients seen during each of the practicum sessions; and
 - (e) Names of facilitators supervised by practitioner students during practicum.

D. Educational programs shall upload the completion certificate into the electronic system designated by the department.

E. Educational programs shall provide current and former students their records upon request.

F. Educational programs shall collect feedback from students within 30 calendar days of the completion of each module, which shall include, at a minimum, ratings and qualitative responses regarding the quality, quantity, and satisfaction of the students with the course pedagogy, materials, presentations, lectures, assignments, evaluations, and course content.

G. Educational programs shall provide records required to be maintained under this rule to the department upon request.

[7.35.3.17 NMAC - N, xx/xx/2026]

7.35.3.18 EDUCATIONAL REQUIREMENTS FOR CERTIFYING CLINICIANS, PRACTITIONERS, AND FACILITATORS:

A. Requirements for certifying clinician, practitioner, and facilitator certification: All certifying clinicians, practitioners, and facilitators who provide medical psilocybin services, including all such providers who

are certified by the department on the basis of having completed an educational program from another jurisdiction, shall complete a New Mexico educational module created or approved by the department prior to applying for certification, which shall include at a minimum:

- (1) Education on the New Mexico Medical Psilocybin Act;
- (2) An overview of the use of psilocybin in a medical and therapeutic model in New Mexico;
- (3) Education on the social, cultural and historical aspects of psilocybin use, including traditional use by Native American and other populations in New Mexico;
- (4) Spiritual, existential, religious, and theological (SERT) aspects of psilocybin therapy; and
- (5) Evaluation to demonstrate competency in the above areas.

B. Requirements for initial certifying clinician certification: All certifying clinicians shall complete a certifying clinician module consisting of a minimum of eight didactic hours prior to applying for certification, which shall include:

- (1) Psilocybin action, interactions, and pharmacology;
- (2) Overview of certifying clinician responsibilities;
- (3) 42 CFR part 2;
- (4) Education on diagnosis of qualifying conditions;
- (5) Determining medical clearance for psilocybin therapy;
- (6) Psychedelic emergencies/urgencies and medical monitoring;
- (7) Research and data collection requirements; and
- (8) Evaluation to demonstrate competency in the above areas.

C. Requirements for initial practitioner and facilitator certification: All practitioners and facilitators shall complete a psilocybin therapy module consisting of a minimum of 65 didactic hours with at least one third of the didactic hours conducted in person, and 10 hours of simulated patient experience, prior to applying for certification. The therapy module shall include the following:

- (1) The didactic portion, which shall address the following topics at a minimum:
 - (a) Overview of practitioner/facilitator responsibilities including how to work as part of a care team;
 - (b) 42 CFR part 2;
 - (c) Trauma-informed Care
 - (d) Psychedelic emergencies, urgencies, complications, and medical monitoring;
 - (e) Safety, risk mitigation, and harm reduction practices;
 - (f) Psilocybin actions and effects on the body, interactions, and pharmacology;
 - (g) Drug interactions and pharmacology;
 - (h) Set and setting;
 - (i) Ethics in therapeutic settings;
 - (j) Legal considerations;
 - (k) Cultural competencies;
 - (l) Traditional and ceremonial practices and considerations;
 - (m) Equity and access;
 - (n) Patient-centered approaches and care;
 - (o) Education on the qualifying conditions and appropriate treatment practices;
 - (p) Preparation and integration sessions;
 - (q) Administration session;
 - (r) Dosing;
 - (s) Psychedelic de-escalation techniques;
 - (t) Non-ordinary states of consciousness;
 - (u) Self-care;
 - (v) Research and data collection requirements;
 - (w) Evidence-informed practices and research updates;
 - (x) Informed consent;
 - (y) Touch and somatic awareness;
 - (z) Continuity of care and creating care plans; and
 - (aa) Evaluation to demonstrate competency in the above areas.
- (2) An in-person simulated patient experience of no less than five hours; and an additional simulated patient experience of no less than five hours, which may be in-person, virtual, either synchronous or

asynchronous, and which shall include evaluation of the student to demonstrate competency. These shall include evaluation of the student to demonstrate competency.

D. Additional requirements for initial facilitator certification: All facilitators shall complete a facilitator-specific training module consisting of a minimum of five didactic hours, prior to applying for certification, which shall include:

- (1) Peer facilitation ethics;
- (2) How to work as part of a care team;
- (3) What it means to be present with a patient;
- (4) For informational purposes: basic concepts of psychotherapy; and
- (5) Evaluation to demonstrate competency in the above areas.

E. Additional requirements for initial practitioner certification: All practitioners shall complete a module on psychedelic and psilocybin therapeutic approaches consisting of a minimum of five didactic hours, prior to applying for certification, which shall include:

- (1) additional education of psilocybin specific therapeutic modalities and non-ordinary states of consciousness;
- (2) education on how to work as part of a care team; and
- (3) evaluation to demonstrate competency in the above areas.

F. Practitioner and facilitator trainings: All practitioners and facilitators shall also complete and maintain proof of current certification prior to applying for medical psilocybin certification in:

- (1) Documentation of current:
 - (a) Basic life support (BLS);
 - (b) Both cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) certification; or
 - (c) Licensure as a New Mexico emergency medical technician (e.g., EMT-basic, EMT-intermediate, EMT-paramedic); and

- (2) Documentation of HIPAA certification completed within the preceding two years.

G. Continuing education requirements for certifying clinicians, practitioners and facilitators:

(1) **Certifying clinicians:** Certifying clinicians shall complete a minimum of eight hours of continuing medical education credits specific to psychedelic medicine or therapy every two years.

(2) **Practitioners and facilitators:** Practitioners and facilitators shall complete a minimum of 20 hours of continuing education credits specific to psychedelic therapy and practice every two years. Practitioners and facilitators shall also keep current with their basic life support, or cardiopulmonary resuscitation and automated external defibrillation certification, or emergency medical technician licensure in addition to the 20 hours of continuing education credits.

H. Waiver of didactic requirements: The department may waive, temporarily suspend, or otherwise reduce the didactic hourly and topic requirements for individuals applying for certification in order to facilitate the certification of individuals trained by other programs, to build the initial infrastructure of the program, or if subsequent evaluations of educational programs determine the changes are appropriate for ensuring competency of the applicants for certification.

[7.35.3.18 NMAC - N, xx/xx/2026]

7.35.3.19 PRACTICUM REQUIREMENTS FOR PRACTITIONERS AND FACILITATORS:

A. Minimum practicum hours; administration day sessions: An individual who seeks to become certified as a practitioner or facilitator shall participate in supervised practice training, otherwise referred to as a “practicum”, after completing at least half of the didactic requirements and all of the simulated patient requirements of the educational requirements. The practicum shall consist of a minimum of 100 hours of supervised practice training for facilitators and 120 hours for practitioners which shall be completed prior to applying for certification. Students shall participate in a minimum of 80 hours of administration day sessions, where students are provided the opportunity to experience, observe, or conduct supervised facilitation of in-person administration day sessions with a minimum of 14 different patients over a minimum of eight different administration and same-day sessions with the following criteria:

- (1) A minimum of six different patients during a minimum of six individual administration day sessions;
- (2) A minimum of two different group administration day sessions with four or more patients in each group administration day session; and

(3) The initial 20 hours of administration day sessions shall be with patients who are determined by the supervising practitioner to be low-risk for adverse events or other complications.

(4) Same-day administration sessions shall include patients who have a diversity of the qualifying conditions.

B. Minimum practicum hours; preparation and integration sessions: Students shall participate in a minimum of 20 hours of in-person preparation and integration sessions, where students are provided the opportunity to experience, observe, or conduct (when licensure allows) preparation or integration sessions. This shall include a minimum of six different patients during individual sessions. This shall include at least one group preparatory and one group integration session with a minimum of four or more patients.

C. Practicum evaluation: As part of the minimum required practicum hours, the student shall present a minimum of two of the last four patients to the practicum supervisor as case presentations for evaluation, and must receive a passing grade on the case presentations to complete their practicum.

D. Practitioner supervision hours: Practitioners shall complete an additional minimum of 20 hours as a practitioner supervising facilitators during in-person administration day sessions, which shall include a minimum of two different patients during individual administration day sessions, and a minimum of one group administration day sessions with a minimum of four or more patients in the group.

E. Practicum location: All practicum hours shall take place in an approved healing center or other approved location.

F. Practicum standards: Practicum supervisors and students shall follow these rules as they apply to facilitation and therapy, shall comply with HIPAA and HITECH confidentiality requirements, and shall comport with applicable limits on scope of practice.

G. Waiver of practicum requirements: The department may otherwise waive, temporarily suspend, or reduce the practicum requirements for individuals applying for certification, in order to facilitate the certification of individuals trained by other government-approved programs, and to build the initial infrastructure of the program.

H. Waiver of practicum hours requirement for applications received by December 31, 2027: An applicant for certification shall not be required to satisfy the full New Mexico practicum hours requirement if the applicant:

(1) Applies for certification by December 31, 2027;
(2) Completes the didactic requirements by December 31, 2027;
(3) Graduates from an educational program that the department certifies by December 31, 2027 or that the department has included on the department-approved list of educational programs by December 31, 2027; and

(4) Demonstrates completion of at least 40 hours of contact time through logs or other records of the sessions, including:

(a) A minimum of two separate individual sessions including the appointments for preparation, administration and integration; and

(b) A minimum of one group session including the appointments for preparation, administration, and integration.

[7.35.3.19 NMAC - N, xx/xx/2026]

7.35.3.20 REQUIREMENTS FOR HEALING CENTERS AND OTHER APPROVED LOCATIONS:

A healing center and a registrant of another approved location shall comply with the following requirements:

A. A healing center and a registrant of another approved location shall maintain a list of all qualified patients who have utilized the location for administration sessions.

B. A healing center shall not possess firearms on the healing center's premises.

C. Medical psilocybin products may only be consumed on the premises of a healing center or other approved location. A healing center and a registrant of another approved location shall not allow the consumption of unauthorized psilocybin products during an administration session. A healing center and a registrant of another approved location shall not promote unregulated cultivation or processing of psilocybin products, and a registrant of another approved location shall not sell psilocybin products that are not lawfully produced or acquired in accordance with department rule.

D. Except in circumstances involving an emergency response, only patients, certified individuals, and students completing their practicums may be present during an administration session unless each patient gives prior written consent for the other individual(s) to be present.

E. A healing center and a registrant of another approved location shall maintain a daily log of all activities related to the purchase, storage, and administration of psilocybin, and shall maintain a copy of information

contained in the log within the electronic system designated by the department, and shall provide information to the department upon request in a form and manner designated by the department.

F. A healing center shall publicly display a copy of its certification from the department.

G. A healing center shall provide the following information to qualified patients:

(1) Information regarding safe transportation of the qualified patient following an administration session;

(2) The healing center's patient bill of rights and responsibilities;

(3) Information explaining informed consent;

(4) Information on how to file a complaint with the department or other relevant state entities; and

(5) How to report an adverse health event to the department.

H. A healing center and a registrant of another approved location shall create and maintain a safety and emergency plan which:

(1) Identifies procedures for evacuating and relocating patients to a safe location if the approved location becomes unsafe;

(2) Identifies general procedures for emergency response when a patient experiences a medical or other emergency;

(3) Identifies procedures for addressing disruptive conduct and patient reactions that do not rise to the level of requiring an emergency response;

(4) Describes how the healing center will address a situation in which a patient attempts to leave an administration session against medical advice; and

(5) Includes procedures to ensure that there are practitioners and facilitators present at all times during an administration session with a minimum of one practitioner and one facilitator for individual patient sessions; and in group administration sessions a minimum of one practitioner for every eight patients and a minimum of one facilitator or qualified student for every two patients. For purposes of the foregoing provision, a student shall be deemed qualified to substitute as a facilitator, including for the purpose of billing, if they are registered with a certified educational program and they have completed at least 50 hours of their practicum. Exception: the department may waive or decrease this requirement if the department determines that the ratio specified presents a barrier for patients and that safety concerns are otherwise alleviated.

I. A healing center and a registrant of another approved location shall provide the emergency and safety plan to all persons who utilize the location.

J. In the event that any emergency procedure is utilized, the healing center or registrant of another approved location shall, within two calendar days, submit a report to the department utilizing the electronic system designated by the department, which shall identify whether the procedures of the safety and emergency plan were adhered to, whether there were deviations from the plan, whether the plan did not work as intended in whole or in part, and what if any procedures the healing center or other approved location intends to modify to ensure safety of individuals in the event of future incidents.

K. A healing center, and a registrant of another approved location, that conducts administration sessions in a natural environment setting that is 15 minutes or more away from emergency medical service response or a hospital, urgent care, or other emergency medical services shall ensure that there is a basic first aid kit and an AED on site, and that there are at least two individuals present during administration sessions who are not receiving treatment and who have:

(1) Wilderness first aid certification;

(2) Wilderness first responder certification; or

(3) Licensure as a New Mexico emergency medical technician (e.g., EMT-basic, EMT-intermediate, EMT-paramedic).

L. All psilocybin products stored at a healing center or other approved location shall be stored within a secure, locked area, which shall be:

(1) An area enclosed on all sides with permanent walls and secured with, at a minimum, a properly installed steel door with a steel frame, and utilizing a commercial grade, non-residential lock;

(2) A locked safe; or

(3) A secure, locked refrigerator or freezer, for products that require refrigeration.

M. A healing center and a registrant of another approved location shall report any potential adverse health event associated with medical psilocybin services to the department no later than two calendar days after the healing center becomes aware of, or is otherwise notified of, the event, using the electronic system designated by the

department. Healing centers and registrants of other approved locations shall maintain records of all adverse health event reports in accordance with these rules. Reports of adverse health events shall include:

- (1) Patient record number;
- (2) Unique identification number of the product(s) used;
- (3) Any challenging psychological, emotional, or behavioral reactions;
- (4) Any participant reaction requiring medical or therapeutic attention;
- (5) Any incident requiring emergency response; and
- (6) Any other incident which has a negative impact on a patient.

N. A healing center and a registrant of another approved location shall timely provide the department access to records, upon the department's request.

[7.35.3.20 NMAC, xx/xx/2026]

7.35.3.21 DEPARTMENT EVALUATION AND ASSESSMENT OF PSILOCYBIN EDUCATIONAL PROGRAMS, HEALING CENTERS, AND OTHER APPROVED LOCATIONS:

A. **Authority to conduct assessments:** The department or its designee may conduct remote or on-site assessments of a psilocybin education program, healing center or other approved location, with or without prior notice, during normal business hours, for the purpose of determining compliance with the Medical Psilocybin Act and this rule. In conducting assessments, the department may review documentation, inspect premises and equipment, and interview staff and patients. Exception: except in emergency circumstances, the department or its designee shall not conduct an on-site assessment during a patient session or at a patient's home without prior written consent from the patient(s).

B. **Curriculum implementation review:** Educational program assessments may include review and observation of the current curriculum, instructional delivery, and related educational activities to determine whether the curriculum is being implemented with fidelity and in accordance with department requirements.

C. **Record retention review:** Assessments shall include a review of the certificant or certificant-applicant record retention plan and verification that the plan is being followed in accordance with all applicable requirements.

D. **Additional documentation:** The department may require any additional documentation it deems reasonably necessary to verify compliance with the Medical Psilocybin Act, this rule, or any other applicable law or regulation. A psilocybin educational program, healing center, or other approved location shall provide requested documentation within the timeframe specified by the department.

[7.35.3.21 NMAC - N, xx/xx/2026]

7.35.3.22 PROHIBITIONS AND LIMITATIONS FOR QUALIFIED PATIENTS AND

CERTIFICANTS: Participation in the medical psilocybin program by a qualified patient or certificant does not relieve the qualified patient or certificant from criminal prosecution or civil penalties for:

- A. Consumption of psilocybin outside an administration session conducted in accordance with the requirements of this rule;
- B. Unlawful distribution, transfer, or use of psilocybin;
- C. Operation of a vehicle while under the influence of psilocybin;
- D. Transport of psilocybin outside of New Mexico, or transport of psilocybin from another state into New Mexico;
- E. Fraudulent representation to a law enforcement officer regarding the person's participation in the program; or
- F. Any other activity not authorized by this rule or the Medical Psilocybin Act.

[7.35.3.22 NMAC, xx/xx/2026]

7.35.3.23 PROHIBITION AGAINST DUAL OWNERSHIP IN CERTIFICANT AND PERMITTEE:

A certificant or a person who holds an ownership interest in a certificant shall not hold an ownership interest in a permittee.

[7.35.3.23 NMAC, xx/xx/2026]

7.35.3.24 COMPLAINTS TO THE DEPARTMENT: A qualified patient or certificant may submit a complaint to the department regarding a certificant in the medical psilocybin program, or regarding any activity or concern related to the medical psilocybin program. The complaint should be in writing, addressed to the medical psilocybin program, and submitted by U.S. certified mail or through the electronic system designated by the

department. The department may request additional information for purposes of its own inquiry. A complaint shall include the name and contact information for the complainant; and a statement of the nature of the complaint and any individuals who may be involved. The department may, within its discretion, choose to conduct a subsequent inquiry, and may request additional information from the complainant for this purpose.
[7.35.3.24 NMAC, xx/xx/2026]

7.34.3.25 INFORMAL ADMINISTRATIVE REVIEW OF DENIED PATIENT APPLICATIONS:

A. Administrative review: An applicant for patient enrollment whose application has been denied may request an informal administrative review from the department.

B. Procedure for requesting informal administrative review:

(1) An applicant given notice of an application denial, and a patient whose enrollment has been immediately suspended, may submit a request for an administrative review through the electronic system designated by the department or mail a written request to the department. To be effective, the request shall:

(a) Be made within 30 calendar days, as determined from the date of the denial notice issued by the department;

(b) State the requestor's name, address, and telephone number;

(c) Provide a brief narrative rebutting the circumstances of the application denial or demonstrate that the issues which resulted in the denial have been resolved; and

(d) If applicable, provide supplemental documentation from the applicant's clinician supporting the medical condition as eligible for the program.

(2) If the applicant wishes to submit additional documentation for consideration, such additional documentation must be included with the request for an administrative review.

(3) A request for administrative review shall not operate to stay or modify the time required for a denied patient applicant to request a formal appeal of the denial pursuant to this rule.

C. Administrative review proceeding: The administrative review proceeding shall be a closed proceeding that is limited to an administrative review of application materials and documents offered to verify eligibility. The administrative review proceeding is not an adjudicatory hearing, and an individual whose initial application for a registry identification number has been denied shall not be entitled to an adjudicatory hearing to contest the denial. The administrative review shall be conducted by the administrative review committee. In cases where the administrative review committee finds the need for additional or clarifying information, the review committee shall request that the applicant supply such additional information within the time set forth in the committee's request.

D. Final determination:

(1) Content and timeline: The administrative review shall be completed, and a decision setting forth the reasons for the decision and the evidence upon which the decision is based, no later than 15 calendar days from the date that the program receives the written request for a record review.

(2) Effect: The decision of the administrative review committee is the final decision of the informal administrative review proceeding.

(3) Notice: A copy of the decision shall be issued to the applicant via certified U.S. postal mail and posted within the electronic system designated by the department.

E. Judicial review: Except as otherwise provided by law, there shall be no right to judicial review of a decision by the administrative review committee.

[7.35.3.25 NMAC, xx/xx/2026]

7.35.3.26 VOLUNTARY WITHDRAWAL FROM ENROLLMENT OR RELINQUISHMENT OF CERTIFICATION:

A qualified patient may voluntarily withdraw from enrollment in the medical psilocybin program, and a practitioner, certifying clinician, facilitator, healing center or other approved location, or educational program may voluntarily relinquish its certification, at any time, by submitting written notice to the department. Upon receipt of such notice, the department shall terminate the enrollment or certification, which shall be effective on the date that the notice is received by the department.

[7.35.3.26 NMAC, xx/xx/2026]

7.35.3.27 DISCIPLINARY ACTIONS AND APPEAL PROCESS FOR ENROLLED PATIENTS, PATIENT-APPLICANTS, CERTIFICANTS, AND APPLICANTS FOR CERTIFICATION:

A. Notices of disciplinary action; grounds for disciplinary action: The department may issue a notice of contemplated action to deny, suspend, or revoke, or take other disciplinary action regarding a patient's

enrollment as a qualified patient in the medical psilocybin program, and may deny, suspend, revoke, or take other disciplinary action regarding the certification of a practitioner, certifying clinician, facilitator, healing center or other approved location, or an educational program. The department may also immediately suspend enrollment or certification if the department determines that such action is necessary to protect the health or safety of a patient or the general public. Notice shall be served via certified U.S. postal mail. A notice shall be deemed to have been served on the date borne by the certified mail return receipt showing delivery or the last attempted delivery, or the refusal of the addressee to accept delivery, at their address of record with the program.

B. Grounds for disciplinary action: Disciplinary action may be imposed based on:

- (1) violation of, or failure to comply with, any provision of this rule or the Medical Psilocybin Act;
- (2) threatening or harming a patient, practitioner, clinician, facilitator, or an employee of a producer, a laboratory, an educational program, a healing center or other approved location, or the department;
- (3) intentionally destroying, damaging, altering, removing, or concealing evidence of a violation of rule or statute; attempting to do so; or asking or encouraging another person to do so;
- (4) conduct that shows willful or reckless disregard for health or safety;
- (5) falsification or misrepresentation of any material or information submitted to the department;
- (6) failure to adhere to any attestation, acknowledgement, verification, or other representation made to the department;
- (7) failure to submit or disclose information required by this rule or otherwise requested by the department;
- (8) for certifying clinicians and practitioners: any determination by the individual's licensing body that the clinician has engaged in unprofessional or dishonorable conduct;
- (9) for certifying clinicians, practitioners, and facilitators: registration in any jurisdiction as a sex offender.

C. Persons who may request a hearing: The following persons may request a hearing to contest an action or proposed action of the department, in accordance with this rule:

- (1) a certified patient;
- (2) a certified practitioner;
- (3) a certifying clinician who was certified by the department;
- (4) a certified facilitator;
- (5) a certified healing center or other approved location;
- (6) a certified educational program; and
- (7) an applicant for enrollment or certification as any of the foregoing, whose application is denied for any reason other than failure to submit a completed application or failure to meet a submittal requirement of this rule.

D. Timing and content of request for hearing: A person who has received a notice of contemplated action to impose a disciplinary action or a notice of immediate disciplinary action pursuant to this section who wishes to request a hearing (hereafter, "the appellant") may do so by mailing a written request for hearing no later than 30 calendar days from the date that the notice of contemplated action is received. The request shall:

- (1) be properly addressed to the medical psilocybin program;
- (2) be mailed to the medical psilocybin program via certified U.S. postal mail (return receipt requested, to verify delivery);
- (3) state the requestor's name, address, and telephone number; and
- (4) include a statement of the issue(s) that the requestor considers relevant to the review of the action.

E. Hearing process:

- (1) All hearings held pursuant to this section shall be conducted by a hearing officer appointed by the secretary.
- (2) Hearings shall be conducted in Santa Fe, NM, provided that, if the appellant is located more than 100 miles from Santa Fe, NM, or if the parties otherwise consent, the hearing may be conducted via telephone or via web video conference.
- (3) Hearings held pursuant to this section that concern patients or patient-applicants shall be closed to the public. Hearings may also be closed in whole or in part, upon the request of a party, to prevent the disclosure of other information that is confidential under applicable law.
- (4) The hearing shall be recorded, at a minimum, by means of sound reproduction.

F. Scheduling: The department shall schedule and hold the hearing as soon as practicable, provided that the hearing shall not be held later than 60 calendar days from the date the department receives the request for hearing. The hearing officer may extend the 60-day time period upon motion for good cause shown, or the parties may extend the 60-day time period by mutual agreement. The department shall issue a notice of hearing, which shall include:

- (1) a statement of the location, date, and time of the hearing;
- (2) a short and plain statement of the legal authority under which the hearing is to be held;
- (3) a short and plain statement of the subject of the hearing.

and

G. Presentation of evidence: All parties shall be given the opportunity to present evidence and argument on all relevant issues.

H. Record of proceeding: The record of the proceeding shall include the following:

- (1) all pleadings, motions, and intermediate rulings;
- (2) evidence and briefs received or considered;
- (3) a statement of matters officially noticed;
- (4) offers of proof, objections, and rulings thereon;
- (5) proposed findings and conclusions; and
- (6) any findings or decisions recommended by the hearing officer for adoption by the

secretary.

I. Recording: A party may request a copy of the recording of the proceedings.

J. Procedures and evidence:

- (1) A party may be represented by a person licensed to practice law in New Mexico or a non-lawyer representative, or may represent themselves.
- (2) The rules of evidence as applied in the courts do not apply in these proceedings. Any relevant evidence shall be admitted. Irrelevant, immaterial, or unduly repetitious evidence may be excluded.
- (3) The experience, technical competence, and specialized knowledge of the hearing officer, the department or the department's staff may be used in the evaluation of evidence.
- (4) An appellant's failure to appear at the hearing at the date and time noticed for the hearing shall, absent good cause, constitute a default.

K. Conduct of proceeding: Unless the hearing officer determines that a different procedure is appropriate, the hearing shall be conducted in accordance with the procedures set forth in this rule. The following procedures shall apply:

- (1) the appellant shall present an opening statement and the department may present an opening statement or reserve the statement until presentation of the department's case;
- (2) after the opening statements, if made, the appellant shall present their case;
- (3) upon the conclusion of the appellant's case, the department shall present its case;
- (4) upon conclusion of the appellee's case, the appellant may present rebuttal evidence; and
- (5) after presentation of the evidence by the parties, the parties may present closing

argument.

L. Burden of proof: The appellant shall bear the burden of establishing by a preponderance of the evidence that the decision made or proposed by the department should be reversed or modified.

M. Continuances: The hearing examiner may grant a continuance for good cause shown. A motion to continue a hearing shall be made at least 10 calendar days before the hearing date.

N. Telephonic and web video hearings:

- (1) Any party requesting that a hearing be conducted via telephone or web video conference shall do so no less than 10 business days prior to the date of the hearing. Notice of the hearing shall be given to all parties and shall include all necessary telephone numbers or instructions for access to the web video conference.
- (2) The in-person presence of some parties or witnesses at the hearing shall not prevent the participation of other parties or witnesses by telephone or web video conference with prior approval of the hearing officer.

O. Recommended action and final decision:

- (1) The parties may submit briefs including proposed findings of fact and conclusions of law for consideration by the hearing officer.
- (2) No later than 30 calendar days after the last submission by a party, the hearing officer shall prepare and submit to the secretary a written recommendation of action to be taken by the secretary. The

recommendation may include proposed findings of fact and conclusions of law for adoption by the secretary, and shall propose sustaining, modifying, or reversing the action or proposed action of the department.

(3) The secretary shall issue a final written decision accepting or rejecting the hearing officer's recommendation in whole or in part no later than 45 calendar days after receipt of the hearing officer's recommendation. The final decision shall identify the final action taken. Service of the secretary's final decision shall be made upon the appellant via certified U.S. postal mail.

(4) The final decision or order shall be included in a medical psilocybin program's file concerning the petitioner.

[7.35.3.27 NMAC - N, 9/22/2026]

7.35.3.28 SEVERABILITY: The provisions of this rule are separate and severable. If any provision of this rule is held to be invalid, unconstitutional, or unenforceable, the remaining provisions shall stay in effect.

[7.35.3.28 NMAC - N, 9/22/2026]

This is an amendment to 7.35.2 NMAC, Sections 7, 10, and 22, effective xx/xx, 2026.

7.35.2.7 DEFINITIONS:

A. Definitions beginning with “A”:

(1) “Actual control” means the ability to:

(a) control the policies, management, or personnel of a permittee;

(b) control strategic priorities, capital allocations, acquisitions, and divestments of a

permittee; or

(c) control a majority of voting rights of a permittee.

(2) “Administrative review committee” means an intra-department committee that reviews

qualified patient application denials in accordance with department rules. The administrative review committee shall consist of the chief medical officer of the department (or that person’s designee); a deputy secretary of the department (or that person’s designee), and the chief nursing officer of the department (or that person’s designee).

~~[(2)]~~ (3) “Administration session” means the session in which medical psilocybin is [administered] consumed by a qualified patient.

~~[(3)]~~ (4) “Adulterate” means to use or incorporate a substance that contaminates a psilocybin product and that creates a risk to public health.

(5) “Adverse health event” means a negative or detrimental medical, physical, behavioral, or psychological reaction associated with medical psilocybin services, whether expected or unexpected, that occurs during or after an administration session and that may or may not require medical or therapeutic intervention.

~~[(4)]~~ (6) “Analytes” means a substance whose chemical constituents are being identified and measured.

~~[(5)]~~ (7) “Appellant” means a person who requests a hearing to contest an immediate or proposed disciplinary action.

~~[(6)]~~ (8) “Approved location” means a location approved by the department for psilocybin administration sessions.

B. Definitions beginning with “B”: “Board” means the medical psilocybin advisory board.

C. Definitions beginning with “C”:

(1) “Capsule” means a small soluble pill, tablet or container that contains homogenized psilocybin material.

(2) “Certificant” means a certifying clinician, practitioner, facilitator, healing center or other approved location, or educational program that is certified by the department to provide medical psilocybin services to qualified patients.

~~[(2)]~~ (3) “Certificate of analysis” or “COA” means a document issued by a permitted psilocybin testing laboratory that reports the results of all analyses required by the department or additional testing requested by a producer or manufacturer.

~~[(3)]~~ (4) “Certification” means an approval issued by the department to a clinician, [or] a practitioner, a facilitator, a healing center or other approved location, or an educational program to [provide medical psilocybin services to qualified patients] participate in the medical psilocybin program.

(5) “Certifying clinician” means a clinician who holds a state of New Mexico controlled substances number, who is certified by the department to diagnose or confirm a previous diagnosis of a qualifying condition and to evaluate the medical appropriateness of a patient enrolling in the New Mexico psilocybin program.

~~[(4)]~~ (6) “Clinician” means an approved health care provider licensed in New Mexico who holds a certification from the department to provide medical services to qualified patients.

~~[(5)]~~ (7) “Compliance notification” means a notification of noncompliance with a regulatory requirement that is issued to a psilocybin producer or psilocybin testing laboratory.

~~[(6)]~~ (8) “Compound” means to prepare psilocybin to tailor dosage, and includes grinding and powdering psilocybin mushrooms, as well as the creation of psilocybin capsules.

~~[(7)]~~ (9) “Convert” means converting psilocybin mushrooms into a homogenized lot.

~~[(8)]~~ (10) “Cultivation” means the growing, harvesting, drying, and handling of psilocybin-producing mushrooms.

~~[(9)]~~ (11) “Cultivation batch” or “batch” means a quantity of unharvested spores, fruiting body, or mycelium that is grown together under the same conditions, that may contain fungi that originates from diverse spores or mycelial tissue.

D. Definitions beginning with “D”: “Department” means the department of health.

E. Definitions beginning with “E”:

(1) **“Educational program”** means a person who is certified by the department to provide educational services for certifying clinicians, practitioners, and facilitators in accordance with this rule.

(2) **“Electronic system”** means a department-approved online system that is used to record and report data, submit applications, and communicate with the department.

(3) **“Enrollment”** means enrollment as a qualified patient for participation in the New Mexico medical psilocybin program.

(4) **“Expiration date”** means a date determined by a producer after which an associated psilocybin product will not retain optimal quality.

F. Definitions beginning with “F”:

(1) **“Facilitator” or “guide”** means an individual who has completed training and education approved by the department to be able to work with patients and practitioners during medical psilocybin services and who has been certified by the department.

~~[(4)]~~ (2) **“Facility”** means any building, space, or grounds licensed for the cultivation, harvesting, drying, storage, or preparation of psilocybin-producing fungi or psilocybin products.

~~[(2)]~~ (3) **“Flush”** means the fruiting body of psilocybin mushrooms harvested at the same time from a growing medium.

~~[(3)]~~ (4) **“Fruiting bodies”** means the spore producing organs of the fungi.

~~[(4)]~~ (5) **“Fungi”** is any member of the group of eukaryotic organisms that includes microorganisms such as yeasts and molds, as well as the more familiar mushrooms.

G. Definitions beginning with “G”:

(1) **“Genuine ownership”** means an ownership interest in ~~[an applicant or]~~ a permittee ~~or permit applicant~~ that is evidenced by record ownership in which the owner, regardless of the amount of capital or assets that the owner contributes to ~~[the applicant or]~~ permittee ~~or permit applicant~~, enjoys the customary incidents of ownership and shares in the profits and losses of the permittee proportionate to the percentage of the owner's interest in the permit.

(2) **“Growth medium” or “substrate”** means the underlying base layer, surface, or nutrient rich substance where fungal growth occurs.

~~[(3)]~~ **“Guide”** ~~an individual who has completed training and education approved by the department to be able to assist practitioners during the administration sessions and who has been registered with the department.]~~

H. Definitions beginning with “H”:

(1) **“Harvest”** means to remove, collect, or gather, fruiting bodies of mushrooms containing psilocybin.

(2) **“Harvest lot”** means the fruiting bodies of mushrooms cultivated and harvested at the permitted location.

(3) **“Healing center”** means a person who has been issued a certification by the department to administer a site at which medical psilocybin administration sessions are conducted, to possess medical psilocybin for that purpose, and to sell or otherwise distribute psilocybin to qualified patients for that purpose.

~~[(3)]~~ (4) **“Homogenization date”** means the date a harvest lot is homogenized.

~~[(4)]~~ (5) **“Homogenized”** means dried fruiting bodies that have been mixed by powdering or other techniques which uniformly distribute psilocybin throughout the product.

~~[(5)]~~ (6) **“Homogenized lot”** means a quantity of psilocybin mushrooms identified by a producer that is cultivated and dried under the same conditions, and harvested within a specified time period at the same location within permitted premises.

I. Definitions beginning with “I”:

(1) **“Information notification”** means a notification providing information regarding relevant updates and alerts that is issued to a psilocybin producer or psilocybin testing laboratory.

(2) **“Inoculate”** means the process of introducing psilocybin spores or mycelium into growth medium.

(3) **“Input”** means material utilized in growing medium for growing psilocybin mushrooms, including but not limited to soil, grain, woodchips, water, nutrients, and other materials.

(4) **“Integration session”** means a therapeutic encounter occurring between a certified practitioner and a patient after the administration of medical psilocybin, in which the practitioner provides ongoing care to the patient.

J. Definitions beginning with “J”: [RESERVED]

K. Definitions beginning with “K”: [RESERVED]

L. Definitions beginning with “L”: [RESERVED]

M. Definitions beginning with “M”:

(1) **“Manufacture”** or **“process”** means to harvest, dry, compound, convert, or package into pills, capsules, or sachets of homogenized powder, and label mushrooms and products containing psilocybin.

(2) **“Medical psilocybin service”** means any medical or therapeutic service related the medical use of psilocybin pursuant to the Medical Psilocybin Act.

~~[(2)]~~ (3) **“Medical services”** means services provided to a patient in an approved setting before, during and after the ingestion of psilocybin and includes a preparation session, an administration session and an integration session.

~~[(3)]~~ (4) **“Mycelium”** means the fungal threads or hyphae of psilocybin containing mushrooms.

~~[(4)]~~ (5) **“Mushroom”** is the fleshy, spore-bearing fruiting body of a fungus.

N. Definitions beginning with “N”: ~~[(RESERVED)]~~ **“New Mexico module”** means requirements for educational study that are created by the department or its designee, that are required by applicable department rule to be completed prior to applying to be a certifying clinician, practitioner, or facilitator.

O. Definitions beginning with “O”: ~~[(RESERVED)]~~ **“Other approved location”** means a site at which medical psilocybin administration sessions are to be conducted, that is not a healing center location, that is certified on a temporary basis by the department for this purpose, and whose certification is applied for by a practitioner, facilitator, or healing center.

P. Definitions beginning with “P”: **[RESERVED]**

(1) **“Package”** means to enclose, wrap, or seal psilocybin products.

(2) **“Permit”** means the authorization issued by the department to a person to operate as a psilocybin producer or psilocybin testing laboratory under this part.

(3) **“Permit-applicant”** means a person who has applied for a permit to operate as a psilocybin producer or psilocybin testing laboratory.

(4) **“Permittee”** means a psilocybin producer or psilocybin testing laboratory that holds a permit issued by the department.

(5) **“Person”** means a natural person, corporation, partnership, limited liability company, association, and any other business or organization that is capable of entering into contracts, owning property, and suing or being sued.

(6) **“Potency”** means the level of psilocybin and analytes in a sample of a batch, lot, or product which is measured and expressed in metric units.

(7) **“Practicum”** means the supervised training of a student who is seeking certification as a practitioner or facilitator and requires participation in preparatory, administration, and integration sessions.

~~[(7)]~~ (8) **“Practitioner”** means ~~[an individual who is a licensed healthcare professional]~~ a clinician who is certified by the department to provide medical psilocybin integrative therapy, supervise ~~[guides]~~ facilitators, and who has completed department required trainings.

(8) **“Preparation session”** means a therapeutic encounter between a certified practitioner and a patient that occurs prior to an administration session.

(9) **“Producer”** means a person who has a permit from the department to grow and harvest or prepare psilocybin from psilocybin-producing mushrooms, including to compound, convert, process or manufacture psilocybin products directly or indirectly from psilocybin mushrooms and to package or repackage or label or relabel the products.

~~[(8)]~~ (10) **“Product lot”** means the same type of product that has been created from a homogenized lot.

~~[(9)]~~ (11) **“Program”** means the medical use of psilocybin program.

~~[(10)]~~ (12) **“Psilocybin”** means the naturally occurring psychedelic compound 4-phosphoryloxy-N, N-dimethyltryptamine, also known as 4-PO-DMT, and its pharmacologically active metabolite psilocin, 4-hydroxy-N, N-dimethyltryptamine, found in certain mushrooms, but does not include synthetic or synthetic analogs of psilocybin.

~~[(11)]~~ (13) **“Psilocybin material”** means psilocybin mushrooms, mycelium, and derived material that naturally contain psilocybin.

~~[(12)]~~ (14) **“Psilocybin mushroom”** means a fungus that naturally contains psilocybin.

~~[(13)]~~ (15) **“Psilocybin producer”** or **“producer”** means a person who has a permit from the department to grow and harvest or prepare psilocybin from psilocybin-producing mushrooms, including to compound, convert, process or manufacture psilocybin products directly or indirectly from psilocybin mushrooms and to package or repackage or label or relabel the products.

~~[(14)]~~ **(16)** “**Psilocybin product**” means psilocybin material that is intended for sale or distribution to a qualified patient.

~~[(15)]~~ **(17)** “**Psilocybin testing laboratory**” or “**laboratory**” means a facility permitted by the department to test psilocybin products for potency and contaminants in accordance with this rule.

~~[(16)]~~ **(18)** “**Psilocybin waste**” means:

- (a)** Partially consumed products;
- (b)** Byproducts of cultivation, harvesting, processing, or other production of products;
- (c)** Products disposed or to be disposed by a producer or laboratory; and
- (d)** Products designated for disposal by the department due to contamination, expiration, or which do not follow the requirements for production and administration.

Q. Definitions beginning with “Q”:

(1) “**Qualified patient**” or “**patient**” means a patient whose certifying clinician has judged the patient to be a medically appropriate candidate for the use of medical psilocybin based on being diagnosed with a qualifying condition.

(2) “**Qualifying condition**” includes:

- (a)** major treatment-resistant depression;
- (b)** posttraumatic stress disorder;
- (c)** substance use disorders;
- (d)** end-of-life care; and
- (e)** other conditions approved by the department;

R. Definitions beginning with “R”:

(1) “**Recall**” means to remove a medical psilocybin product from the medical psilocybin market by contacting persons to whom the product was sold or otherwise distributed and having the product returned to the producer for destruction.

(2) “**Registrant of another approved location**” means a practitioner, facilitator, or healing center who applies for and receives certification for an “other approved location”.

S. Definitions beginning with “S”:

(1) ~~“**Satchet**”~~ **“(Satchet)”** “**Sachet**” means a small, sealed package or pouch of homogenized psilocybin mushrooms.

(2) “**Secretary**” means the secretary of health.

(3) “**Sex offender**” means a person who is convicted of a sex offense pursuant to state, federal, tribal, military, or other law of New Mexico, another state, commonwealth, or territory, or pursuant to the laws of a jurisdiction outside the United States.

(4) “**Sex offense**” means any offense that is deemed a sex offense for purposes of the New Mexico Sex Offender Registration and Notification Act, NMSA 1978, Section 29-11A-3.

T. Definitions beginning with “T”:

(1) “**Testing sample**” means the unit of psilocybin mushrooms or products being tested.

(2) “**Traceability system**” means the department-approved system that is used to track psilocybin mushrooms and products from inoculation to end use.

U. Definitions beginning with “U”: “**Unique identification number**” means the most recent unique number assigned by the traceability system for a psilocybin product that may include cultivation batches, harvest lots, homogenized lots, product lots, and testing samples.

V. Definitions beginning with “V”: [RESERVED]

W. Definitions beginning with “W”: [RESERVED]

X. Definitions beginning with “X”: [RESERVED]

Y. Definitions beginning with “Y”: [RESERVED]

Z. Definitions beginning with “Z”: [RESERVED]

[7.35.2.7 NMAC - N, 6/23/2026; A, xx/xx/2026]

7.35.2.10 GENERAL PRODUCER REQUIREMENTS:

A. A producer shall:

(1) Only cultivate, manufacture, and possess psilocybin and psilocybin products on the producer’s permitted premises, and shall not transport psilocybin outside the state of New Mexico.

(2) Use equipment, counters and surfaces for post-harvest processing that are food-grade and do not react adversely with any solvent being used.

(3) Construct and maintain floors, walls, ceilings, counters and surface areas in a manner that reduces the potential development of microbials, molds, and unintended fungi.

(4) Maintain the licensed premises in a manner that is free from conditions that may result in contamination of psilocybin products and that is suitable for safe and sanitary operations.

(5) Store all psilocybin products in a secured, locked area, including psilocybin products that require refrigeration.

(6) Associate every cultivation batch, harvest lot, homogenized lot, and product lot with a unique identification number and enter this information into the traceability system.

(7) Only sell psilocybin or psilocybin products to other producers, healing centers, and ~~[to]~~ practitioners; and only otherwise distribute psilocybin or psilocybin products to medical psilocybin testing laboratories, or to department employees for testing in accordance with this rule.

(8) Immediately discontinue operations and notify the department in the event of an imminent health hazard that could result in contamination of psilocybin products.

[7.35.2.10 NMAC - N, 6/23/2026; A, xx/xx/2026]

7.35.2.24 REQUIREMENTS FOR THE TRANSPORTATION OF PSILOCYBIN:

A. General requirements: Producers shall develop and maintain a plan for safe transportation of psilocybin which shall include the following requirements:

(1) transportation of psilocybin shall only be conducted by persons holding a permit or designated employees, or contractors of a permittee ~~[or]~~ , certified practitioner, or certified healing center;

(2) prior to transporting psilocybin a permittee must complete a chain of custody form, only the psilocybin listed on the chain of custody form may be transported;

(3) psilocybin shall only be transported inside of a motor vehicle in reasonable operating condition and shall not be visible or identifiable from outside of the vehicle;

(4) psilocybin shall be locked in a box, container, or cage that is secured within the inside of the vehicle, including when such a box, container, or cage is located inside of the trunk;

(5) vehicles shall be locked and secured while left unattended;

(6) vehicles shall have a vehicle alarm system;

(7) psilocybin shall not be tampered with, or opened, during transport;

(8) a person who transports psilocybin or psilocybin products may transport to multiple approved locations during one trip;

(9) a person who transports psilocybin or psilocybin products shall not deviate from the travel requirements described in this section, except for necessary rest, fuel, or vehicle repair stops;

(10) vehicles transporting psilocybin are subject to inspection by the department at any permitted premises or during transport at any time;

(11) storage and transportation of psilocybin shall be under conditions that will maintain and protect it against physical, chemical, and microbial contamination as well as against deterioration of the psilocybin and the container;

(12) the vehicle must be properly registered with the New Mexico motor vehicle division; and

(13) the driver of the vehicle must be prepared to show proper identification, including an employee badge, driver's license, vehicle registration and proof of insurance, and the appropriate chain of custody form to law enforcement and the department when requested.

B. Chain of custody form: Prior to transporting psilocybin, a permittee shall generate and submit a chain of custody form through the traceability system for the following activities:

(1) testing and sampling of psilocybin;

(2) sale of psilocybin; and

(3) destruction, wastage, or disposal of psilocybin.

C. Verification of chain of custody form: The ~~[permittee]~~ person receiving the psilocybin shipment ~~[will]~~ shall verify the psilocybin is accurately reflected in the chain of custody.

D. Rejection of shipment: ~~[Permittees]~~ Persons shall not take into possession or transport:

(1) Any psilocybin that is not on the chain of custody form; or

(2) Any psilocybin that is less than or greater than the amount reflected on the chain of custody.

E. Responsibility for discrepancy: A permittee who transports a psilocybin product shall be responsible for any discrepancy between the chain of custody form and the psilocybin product in their possession during transport.

F. Void or change prohibited: A permittee shall not void or alter a chain of custody document after departing from the originating licensed premises.

G. Documentation of all transport: A chain of custody document shall accompany every transport of psilocybin or a psilocybin product.

[7.35.2.24 NMAC - N, 6/23/2026; A, xx/xx/2026]

NOTICE OF PUBLIC HEARING

The New Mexico Department of Health (Department) will hold a public hearing on the proposed adoption of a new rule, 7.35.3 NMAC, concerning the New Mexico Medical Psilocybin Program (“Program”), and proposed amendments to Program rule sections 7.35.2.7 NMAC, 7.35.2.10, and 7.35.2.24 NMAC. The hearing will be held on Friday, October 2, 2026 at 9:00 a.m. in the Harold Runnels Building auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico. The hearing will also be broadcast via a live web-based video conference, and via telephone. Members of the public who wish to submit public comment regarding the proposed rule will be able to do so in person at the hearing, via video conference, or via telephone during the hearing, and by submitting written comment.

The rule 7.35.3 NMAC proposes to adopt standards for patient enrollment in the New Mexico Medical Psilocybin Program, as well as standards concerning certifying clinicians, practitioners, facilitators, healing centers and other approved locations, and educational programs in the NM Medical Psilocybin Program. The rule includes, but is not limited to, the following:

- Application requirements for patients;
- Application requirements, operating requirements, data submittal requirements, and prohibitions for certifying clinicians, practitioners, facilitators, healing centers and other approved locations, and educational programs;
- Curriculum and didactic requirements for educational programs;
- Provisions for Department evaluation and assessment of educational programs, healing centers and other approved locations;
- Requirements for third-party evaluators of educational programs;
- Educational requirements for certifying clinicians, practitioners, and facilitators;
- Practitioner and facilitator practicum requirements;
- Educational program mentoring requirements;
- Provisions for reciprocal enrollment by certifying clinicians, practitioners, and facilitators, and for reciprocal recognition of educational programs;
- Provisions for administrative review of denied initial patient applications;
- Prohibitions and limitations for qualified patients and certificants;
- Emergency planning and adverse health event reporting requirements for healing centers and other approved locations;
- Protocols for storage and handling of psilocybin products; and
- Provisions for the denial, suspension, revocation, or other disciplinary action against, a patient’s enrollment or application for enrollment, and against the certification or application for certification of a certifying clinician, practitioner, facilitator, healing center or other approved location, or educational program; and a hearings process for those persons to appeal the decision or proposed decision of the Department.

The proposed amendment to 7.35.2.7 NMAC would revise definitions used in Medical Psilocybin Program rules.

The proposed amendment to 7.35.2.10(G) NMAC would revise general producer requirements.

The proposed amendment to 7.35.2.24 NMAC would revise requirements concerning the transportation of psilocybin.

The purpose of the proposed rule 7.35.3 NMAC and proposed amendments to 7.35.2.7, 7.35.2.10(G), and 7.35.2.24 NMAC is to implement the Medical Psilocybin Act, sections 26-2D-1 through -11, NMSA 1978.

The legal authority authorizing the adoption of this rule by the Department is the Department of Health Act, subsection E of section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health to “...make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions,”; and the Medical Psilocybin Act, at section 26-2D-7, NMSA 1978, which requires the Department to establish:

- appropriate qualifying conditions for qualified patients;
- necessary initial and ongoing training for producers and clinicians;
- treatment protocols, including patient selection criteria, medical service standards, dosage standards and approved settings for administration of psilocybin to patients;
- safety protocols for transporting, storing and handling psilocybin and treating patients;
- other best practices for producers and clinicians;
- requirements for data collection to evaluate the program and the use of best practices by producers and clinicians; and
- other requirements, restrictions and limitations to ensure an efficacious program.

A free copy of the full text of the proposed rule can be obtained online from the New Mexico Department of Health's website at <http://nmhealth.org/about/asd/cmo/rules/> or by contacting the Department using the contact information below.

The public hearing will be conducted to receive public comment on the proposed rule. Any interested member of the public may attend the hearing and may submit data, views, or arguments on the proposed rule either orally or in writing during the hearing.

The hearing will be held on October 2, 2026 at the Harold Runnels Building auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico.

To access the hearing via the Internet: please go to <https://www.microsoft.com/en-us/microsoft-teams/join-a-meeting> and then enter the following meeting i.d. code and passcode where indicated on the screen: meeting i.d. code 283 701 292 311 099 and passcode Cx9ND6Pk and then click the "Join a meeting" button.

To access the hearing by telephone: please call 1-505-312-4308 and enter phone conference i.d. 120 257 56#

Individuals who wish to receive an e-mailed calendar invitation for the hearing may register online at <https://events.gcc.teams.microsoft.com/event/6f41bc8d-b848-4eb7-88ec-3f0ca5f9ade6@04aa6bf4-d436-426f-bfa4-04b7a70e60ff>

All comments will be recorded.

Written public comment regarding the proposed rule can be submitted either by e-mail to Jacob Clark at jacob.clark@doh.nm.gov, or by U.S. postal mail to the following address:

Jacob Clark
NMDOH OGC
P.O. Box 26110
1190 St. Francis Dr., Suite N-4095
Santa Fe, NM 87502-6110

Written comments must be received by the close of the public rule hearing October 2, 2026. All written comments will be published on the agency website at <https://www.nmhealth.org/about/asd/cmo/rules/> within 3 days of receipt, and will be available at the New Mexico Department of Health for public inspection.

If you are an individual with a disability and need special assistance or accommodation to attend or participate in the hearing, please contact Jacob Clark by telephone at (505) 827-2997. The Department requests at least ten (10) days' advance notice to provide special accommodation.

Affidavit of Publication

STATE OF NEW MEXICO } SS
COUNTY OF BERNALILLO }

Ad Cost: \$326.48
Ad Number: 450440
Account Number: 1060434
Classification: GOVERNMENT LEGALS

I, Michele Aster, the undersigned, Legal Representative of the Albuquerque Journal, on oath, state that this newspaper is duly qualified to publish legal notices or advertisements within the meaning of Section 3, chapter 167, Session Laws of 1937, and payment of fees has been made of assessed and a copy of which is hereto attached, was published in said publication in the daily edition, 1 time on the following date:

August 25, 2026

That said newspaper was regularly issued and circulated on those dates.

SIGNED:



Legal Representative

Subscribed to and sworn to me this 25th day of August 2026.



Notary Public

County

Bernalillo

ID#: 1140229

My commission expires: 04-26-2027

STATE OF NEW MEXICO NOTARY PUBLIC DAVID LINDSEY MONTOYA COMMISSION NUMBER 1140229 EXPIRATION DATE 04-26-2027
--

NM DEPT OF HEALTH
OFFICE OF GENERAL COUNSEL
PO BOX 26110, SUITE N-4095
SANTA FE, NM 87502

NOTICE OF PUBLIC HEARING

The New Mexico Department of Health (Department) will hold a public hearing on the proposed adoption of a new rule, 7.35.3 NMAC, concerning the New Mexico Medical Psilocybin Program ("Program"), and proposed amendments to Program rule sections 7.35.2.7 NMAC, 7.35.2.10, and 7.35.2.24 NMAC. The hearing will be held on Friday, October 2, 2026 at 9:00 a.m. in the Harold Runnels Building auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico. The hearing will also be broadcast via a live web-based video conference, and via telephone. Members of the public who wish to submit public comment regarding the proposed rule will be able to do so in person at the hearing, via video conference, or via telephone during the hearing, and by submitting written comment.

The rule 7.35.3 NMAC proposes to adopt standards for patient enrollment in the New Mexico Medical Psilocybin Program, as well as standards concerning certifying clinicians, practitioners, facilitators, healing centers and other approved locations, and educational programs in the NM Medical Psilocybin Program. The rule includes, but is not limited to, the following:

- Application requirements for patients;
- Application requirements, operating requirements, data submittal requirements, and prohibitions for certifying clinicians, practitioners, facilitators, healing centers and other approved locations, and educational programs;
- Curriculum and didactic requirements for educational programs;
- Provisions for Department evaluation and assessment of educational programs, healing centers and other approved locations;
- Requirements for third-party evaluators of educational programs;
- Educational requirements for certifying clinicians, practitioners, and facilitators;
- Practitioner and facilitator practicum requirements;
- Educational program mentoring requirements;
- Provisions for reciprocal enrollment by certifying clinicians, practitioners, and facilitators, and for reciprocal recognition of educational programs;
- Provisions for administrative review of denied initial patient applications;
- Prohibitions and limitations for qualified patients and certificants;
- Emergency planning and adverse health event reporting requirements for healing centers and other approved locations;
- Protocols for storage and handling of psilocybin products; and
- Provisions for the denial, suspension, revocation, or other disciplinary action against, a patient's enrollment or application for enrollment, and against the certification or application for certification of a certifying clinician, practitioner, facilitator, healing center or other approved location, or educational program; and a hearings process for those persons to appeal the decision or proposed decision of the Department.

The proposed amendment to 7.35.2.7 NMAC would revise definitions used in Medical Psilocybin Program rules.

The proposed amendment to 7.35.2.10(G) NMAC would revise general producer requirements.

The proposed amendment to 7.35.2.24 NMAC would revise requirements concerning the transportation of psilocybin.

The purpose of the proposed rule 7.35.3 NMAC and proposed amendments to 7.35.2.7, 7.35.2.10(G), and 7.35.2.24 NMAC is to implement the Medical Psilocybin Act, sections 26-2D-1 through -11, NMSA 1978.

The legal authority authorizing the adoption of this rule by the Department is the Department of Health Act, Subsection E of section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health to "...make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions,"; and the Medical Psilocybin Act, at section 26-2D-7, NMSA 1978, which requires the Department to establish:

- appropriate qualifying conditions for qualified patients;
- necessary initial and ongoing training for producers and clinicians;
- treatment protocols, including patient selection criteria, medical service standards, dosage standards and approved settings for administration of psilocybin to patients;
- safety protocols for transporting, storing and handling psilocybin and treating patients;
- other best practices for producers and clinicians; - requirements for data collection to evaluate the program and the use of best practices by producers and clinicians; and
- other requirements, restrictions and limitations to ensure an efficacious program.

A free copy of the full text of the proposed rule can be obtained online from the New Mexico Department of Health's website at <http://nmhealth.org/about/asd/cmo/rules/> or by contacting the Department using the contact information below.

The public hearing will be conducted to receive public comment on the proposed rule. Any interested member of the public may attend the hearing and may submit data, views, or arguments on the proposed rule either orally or in writing during the hearing.

The hearing will be held on October 2, 2026 at the Harold Runnels Building auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico.

To access the hearing via the Internet: please go to <https://www.microsoft.com/en-us/microsoft-teams/join-a-meeting> and then enter the following meeting i.d. code and passcode where indicated on the screen: meeting i.d. code 283 701 292 311 099 and passcode Cx9ND6Pk and then click the "Join a meeting" button.

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All comments will be recorded.

Written public comment regarding the proposed rule can be submitted either by e-mail to Jacob Clark at jacob.clark@doh.nm.gov, or by U.S. postal mail to the following address:

Jacob Clark
NMDOH OGC
P.O. Box 26110
1190 St. Francis Dr., Suite N-4095
Santa Fe, NM 87502-6110

Written comments must be received by the close of the public rule hearing October 2, 2026. All written comments will be published on the agency website at <https://www.nmhealth.org/about/asd/cmo/rules/> within 3 days of receipt, and will be available at the New Mexico Department of Health for public inspection.

If you are an individual with a disability and need special assistance or accommodation to attend or participate in the hearing, please contact Jacob Clark by telephone at (505) 827-2997. The Department requests at least ten (10) days' advance notice to provide special accommodation.

Journal: August 25, 2026.

INVOICE

**NM Commission of Public
Records**
1205 Camino Carlos Rey
Santa Fe, NM 87507

darlene.martinez@srca.nm.gov
+1 (505) 476-7913
www.nmcpr.state.nm.us

**Bill to**

Department of Health - General Counsel
Office
P.O. Box 26110
Santa Fe, NM 87502-6110

Ship to

Department of Health - General Counsel
Office
P.O. Box 26110
Santa Fe, NM 87502-6110

Invoice details

Invoice no.: SRCA 8978
Terms: Due on receipt
Invoice date: 08/28/2026
Due date: 08/28/2026

Volume: XXXVII
Issue: 16
P.O. number: 66500-0000212543

#	Product or service	Description	Qty	Rate	Amount
1.	NM Register - 431902	Notice of Public Hearing (7.35.3 NMAC), hearing date: 10/2/2026	36	\$3.00	\$108.00

Total**\$108.00****Note to customer**

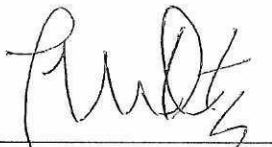
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Affidavit of Publication in New Mexico Register

I, Matthew Ortiz, certify that the agency noted on Invoice # SRCA - 8978 has published legal notice of rulemaking or rules in the NEW MEXICO REGISTER, VOLUME XXXVI, that payment has been assessed for said legal notice of rulemaking or rules, which appears on the publication date and in the issue number noted on Invoice # SRCA - 8978, and that Invoice # SRCA - 8978 has been sent electronically to the person(s) listed on the *Billing Information Sheet* provided by the agency.

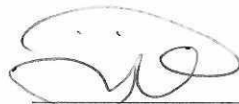
Affiant:

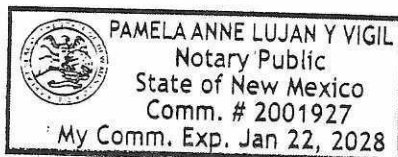

Matthew Ortiz

Subscribed, sworn and acknowledged before me this 31st day of August 2026.

Notary Public:

My Commission Expires:


1/22/2028



1205 Camino Carlos Rey | Santa Fe, NM 87507 | www.srca.nm.gov

Hon. Raúl Torrez
Attorney General

Hon. Joseph Maestas
State Auditor

Hon. Maggie Toulouse Oliver
Secretary of State

Debra Garcia y Griego
Secretary, Department of Cultural Affairs

Robert E. Doucette Jr.
Secretary, General Services Department

Stephanie Wilson
State Law Librarian, Supreme Court Law Library



Michelle Lujan Grisham
Governor

Gina DeBlassie
Cabinet Secretary

New Mexico Department of Health

Exhibit 6

Via Electronic Mail

August 24, 2026

Craig Erickson
Utton & Kery, P.A.
PO Box 2386
Santa Fe, NM 87504
E-mail: craig@uttonkery.com

Re: Appointment Letter, Public Rulemaking Hearing on Proposed Adoption of a New Rule 7.35.3 NMAC, the New Mexico Psilocybin Program - Patients, Certifying Clinicians, Practitioners, Facilitators, Healing Centers, Other Approved Locations, and Educational Programs

Dear Mr. Erickson:

Pursuant to NMSA 1978, § 9-7-6(E), I hereby appoint you to serve as the hearing officer to preside at the Department of Health's public hearing October 2nd, 2026, and to submit a written recommendation regarding the proposed rule adoption. This rulemaking hearing is scheduled for 9:00 a.m. and will be a hybrid rule hearing, conducted in-person at the Harold Runnels Building auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico 87505, and via the Microsoft Teams web conference platform and via telephone. Attached is a copy of the Notice of Public Hearing.

The hearing will be conducted to receive public comment regarding the adoption of a new rule, 7.35.3 NMAC, "New Mexico Psilocybin Program - Patients, Certifying Clinicians, Practitioners, Facilitators, Healing Centers, Other Approved Locations, and Educational Programs". An exhibit binder will be provided to you prior to the date of the hearing.

Thank you for accepting this appointment.

Sincerely,

Gina DeBlassie
NMDOH Cabinet Secretary

8/24/2026
Date

cc: Christopher D. Woodward, Deputy General Counsel

Affidavit of Notice to the Public

I, Jacob Clark, the undersigned, on oath, swear and affirm that the Notice of the Public Hearing for the proposed adoption of rule 7.35.3 (Patients, Certifying Clinicians, Practitioners, Facilitators, Healing Centers, Other Approved Locations, and Educational Programs), was provided to the public as identified below:

1. On August 25th, 2026, I verified that the Notice of Public Hearing was electronically posted on the New Mexico Department of Health agency website at <https://www.nmhealth.org/about/asd/cmo/rules/>, in accordance with the State Rules Act at NMSA 1978, § 14-4-5.2.
2. On August 25th, 2026, I verified that the Notice of Public Hearing was posted on the New Mexico Sunshine Portal website, in accordance with the State Rules Act at NMSA 1978, § 14-4-5.2.
3. On August 25th, 2026, I emailed the Notice of Public Hearing to persons who have made a written request for notice from the agency of announcements addressing the subject of rulemakings and who have provided the agency an electronic mail address, in accordance with the State Rules Act at NMSA 1978, § 14-4-5.2. The list of persons who requested notice includes the following persons:

Tim Gardner	tgardner@drnm.org
Lucy Galaviz	lgalaviz@drnm.org
Rachel S. Gudgel	rachel.gudgel@nmlegis.gov

4. No persons have provided a postal address to request written notice by postal mail.
5. On August 25th, 2026, I emailed the Notice of Public hearing to the New Mexico Legislative Council Service, at lcs@nmlegis.gov, in accordance with the State Rules Act at NMSA 1978, § 14-4-5.2.
6. On August 25th, 2026, I emailed the Notice of Public Hearing to Kate Graham of the New Mexico Small Business Regulatory Advisory Commission, the identified contact person for the receipt of proposed rule changes, at Kate.Graham@edd.nm.gov, pursuant to the Small Business Regulatory Relief Act at NMSA 1978, § 14-4A-4.
7. On August 25th, 2026, I ensured that the Notice of Public Hearing was posted publicly on the exterior doors at the Harold Runnels Building, Department of Health, 1190 S. St. Francis Drive, Santa Fe, NM 87505.

FURTHER AFFIANT SAYETH NAUGHT.



Jacob Clark, Affiant

STATE OF NEW MEXICO }
COUNTY OF SANTA FE }

SWORN TO and SUBSCRIBED before me on the 25 day of August, 2026 by Jacob Clark.



Notarial Officer



State of New Mexico
Notarial Officer
Melinda L. Wolinsky
State Bar #5903

My Commission Expires:



From: [Ian Dunn](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Proposed Rule Comment: 7.35.3
Date: Saturday, September 5, 2026 4:40:43 PM
Attachments: [publickey - idunn.nm@pm.me - 0x0DABD13C.asc](#)
[signature.asc](#)

Dear New Mexico Department of Health,

My name is Ian Dunn, and I serve as Chair of the Medical Psilocybin Advisory Board. While I strongly support the regulatory framework proposed in NMAC 7.35.3, I am writing to express serious concern regarding the provision requiring property owner approval before a patient may receive services in their home. This requirement introduces an unjustified barrier to care, infringes on patient privacy, and misaligns with New Mexico housing law.

Under NMSA 1978, Section 47-8-25 of the Uniform Owner-Resident Relations Act, a resident is required to occupy and use their leased premises as a dwelling in compliance with their rental agreement. Receiving professional health or supportive care in one's home; whether delivered by nurses, aides, hospice workers, or licensed psilocybin facilitators, is an established facet of domestic life. It does not convert a residential dwelling into a commercial or nonresidential operation.

Mandating affirmative landlord consent imposes significant harm without a corresponding public health or safety benefit:

- **Compromised Patient Privacy:** It forces patients, including those with serious or terminal illnesses, to disclose confidential medical decisions to third-party landlords who have no clinical role or legal entitlement to that information.
- **Disproportionate Barriers to Care:** It effectively grants landlords veto power over lawful, medically appropriate care within a tenant's private residence, disproportionately affecting vulnerable populations and individuals receiving hospice care.
- **Administrative Overreach:** Requiring third-party property owner authorization for private healthcare delivery sets an unprecedented standard that departs from how other home-based health services are regulated in the state.

To preserve essential regulatory safeguards while protecting equitable access, I recommend replacing the landlord-permission requirement with a standard requiring proof of lawful residence or lawful occupancy of the location.

This adjustment ensures that services are conducted in verified, secure residences without creating unnecessary housing-related obstacles to necessary patient care. Thank you for your consideration of this critical revision.

Sincerely,

Ian Dunn

Chair | Medical Psilocybin Advisory Board

From: [Dr. Trish Singh](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] RE: Public Comment on Proposed 7.35.3 NMAC — Patients, Certifying Clinicians, Practitioners, Facilitators, Healing Centers, Other Approved Locations, and Educational Programs
Date: Wednesday, September 16, 2026 1:56:22 PM

You don't often get email from trishsingh19@outlook.com. [Learn why this is important](#)

CAUTION: This email originated outside of our organization. Exercise caution prior to clicking on links or opening attachments.

September 16, 2026

New Mexico Department of Health
Office of General Counsel
Medical Psilocybin Program

To the New Mexico Department of Health:

My name is Patricia Singh, PhD, LPCC. I am an independently licensed behavioral health clinician in New Mexico, a New Mexico Board-Approved Clinical Supervisor, and the Owner and Executive Director of A New Awakening, an outpatient behavioral health organization serving individuals with substance use disorders, including individuals involved in New Mexico's criminal justice system. I am also a co-founder of Trip HōM, a psychedelic-care organization. I have completed psychedelic-assisted therapy training through the California Institute of Integral Studies and hold Colorado Natural Medicine Facilitator and Handler credentials.

I appreciate the Department's work to develop a thoughtful, clinically responsible regulatory framework for implementing the Medical Psilocybin Act. My comments focus on several implementation issues arising at the intersection of behavioral health, substance use disorder treatment, justice-system involvement, clinician training, and equitable access.

1. Clarify and preserve the transitional pathway for experienced practitioners

I strongly support rigorous education and competency standards for practitioners. I also appreciate that the proposed rule recognizes that experienced clinicians and psychedelic practitioners may enter New Mexico's program with substantial prior education and supervised experience.

Proposed §7.35.3.10 provides a pathway for applicants who completed qualifying educational programs in other jurisdictions and permits recognition of certain government-approved programs and programs developed in collaboration with institutions of higher education or government-approved psychedelic research studies.

Proposed §7.35.3.19(H) further provides that applicants meeting specified requirements and applying by December 31, 2027, may satisfy a reduced practicum requirement by demonstrating at least 40 hours of documented contact time rather than completing the full New Mexico practicum.

This transitional pathway will be important to New Mexico's ability to build a competent initial workforce without requiring experienced professionals to unnecessarily duplicate

training and supervised clinical experience.

I respectfully request that the Department provide clear guidance regarding:

- the documentation required to establish equivalency of education completed outside New Mexico;
- whether documented preparation, administration/facilitation, integration, supervision, and practicum experience obtained through another regulated state program may be credited toward the transitional requirements;
- how established psychedelic-assisted therapy programs completed before New Mexico's educational programs existed will be evaluated; and
- what forms of logs, supervision records, patient-contact documentation, or other records will be accepted to establish the required 40 hours of contact time.

I also request clarification of an apparent inconsistency within the proposed rule. Section 7.35.3.10(D)(1) describes the reduced practicum pathway as requiring at least 40 hours of contact time with a minimum of two separate individual sessions and **two separate group sessions** involving preparation, administration, and integration. Section 7.35.3.19(H), however, describes at least 40 hours with a minimum of two separate individual sessions and **one group session** involving preparation, administration, and integration.

I respectfully request that the Department reconcile these provisions in the final rule so prospective applicants clearly understand the transitional practicum requirement.

2. Provide implementation guidance for qualified patients involved in the criminal justice system

Substance use disorders are expressly included among the qualifying conditions under the Medical Psilocybin Act. The Act also contains unusually important protections for individuals involved in the criminal justice system.

Section 26-2D-10 NMSA 1978 provides that a person serving a period of probation or parole, or who is in the custody or under the supervision of the state or a local government pending trial as part of a community-supervision program, shall not be penalized for participation in the Medical Psilocybin Program.

As a behavioral health provider who has worked extensively with justice-involved individuals with substance use disorders, I believe implementation guidance in this area would be valuable to patients, clinicians, courts, probation departments, diversion programs, and treatment providers.

I respectfully encourage the Department to clarify that:

- justice-system involvement does not itself disqualify an otherwise qualified patient;
- a referral originating from a treatment court, probation department, diversion program, behavioral health provider, attorney, or other justice-system participant does not itself make participation involuntary;

- participation in medical psilocybin treatment must remain voluntary and based upon independent clinical determination of eligibility and medical appropriateness;
- declining medical psilocybin treatment should not itself result in an adverse consequence within a state or local treatment, diversion, probation, or community-supervision program; and
- the protections provided by the Medical Psilocybin Act apply consistently throughout program implementation.

Clear guidance would help prevent inconsistent interpretations across jurisdictions while protecting both patient autonomy and the integrity of the Medical Psilocybin Program.

3. Protect substance use disorder confidentiality in justice-system referrals

The proposed educational requirements appropriately include training regarding 42 CFR Part 2. This is particularly important because substance use disorder is a qualifying condition and because some patients may enter the program while participating in treatment courts, diversion programs, probation, reentry services, or other justice-related programs.

I encourage the Department to provide implementation guidance on exchanging information between Medical Psilocybin Program providers and justice-system referral sources.

Such guidance should distinguish between information that may lawfully and appropriately be disclosed pursuant to a valid authorization or other applicable legal authority and detailed clinical information that should remain protected.

Participation in a justice-related program should not, by itself, result in automatic disclosure of a patient's subjective psychedelic experience, therapeutic disclosures, trauma history, family information, dosage information, psychotherapy content, or other protected clinical information.

Clear guidance concerning 42 CFR Part 2, HIPAA, applicable state confidentiality requirements, and properly structured releases of information would help clinicians collaborate appropriately with justice-system partners while preserving the confidentiality necessary for effective substance use disorder treatment.

4. Preserve integration with existing behavioral health and healthcare systems

Medical psilocybin treatment should function within a broader continuum of care rather than as an isolated episode.

Many patients with substance use disorders already receive behavioral health services through Medicaid, commercial insurance, public programs, or other healthcare coverage. Assessment, ongoing SUD treatment, psychotherapy, medical evaluation, preparation, integration, relapse-prevention services, and continuing behavioral healthcare may constitute independently medically necessary healthcare services when delivered by appropriately licensed and credentialed professionals and when applicable payer requirements are satisfied.

I encourage the Department to ensure that its final rules and subsequent guidance do not inadvertently require independently provided healthcare services to be financially bundled into the cost of psilocybin administration when those services are otherwise appropriately provided

and reimbursable through existing healthcare systems.

Integration with existing healthcare infrastructure could substantially improve continuity of care and affordability while allowing treatment-equity resources, philanthropy, and other access mechanisms to cover costs not otherwise covered.

This will be particularly important for Medicaid beneficiaries, economically disadvantaged patients, rural communities, and justice-involved individuals.

5. Monitor the access impact of administration-session staffing requirements

Proposed §7.35.3.20(H) generally requires at least one practitioner and one facilitator during an individual administration session and establishes staffing ratios for group administration sessions. I appreciate that the proposed rule also allows the Department to waive or decrease the staffing requirement when the specified ratio presents a barrier for patients and safety concerns are otherwise alleviated.

I support maintaining appropriate safety standards. I also encourage the Department to develop a transparent and clinically grounded process for obtaining such a waiver.

Requiring two certified professionals for every individual administration session could materially increase treatment costs and reduce access, particularly in rural areas and for patients relying on the Treatment Equity Fund or philanthropic assistance.

Clear waiver criteria based on patient risk, practitioner qualifications, treatment setting, emergency planning, proximity to emergency medical services, and other relevant clinical factors could preserve safety while preventing staffing requirements from becoming an unintended barrier to access.

6. Preserve meaningful access through “other approved locations”

I support the proposed framework allowing temporary certification of “other approved locations” when a patient cannot be transported to a healing center, when medical necessity supports another location, to improve access in rural and frontier counties, or to enable treatment in a natural environment.

This flexibility is particularly relevant in a geographically large and rural state such as New Mexico.

I respectfully request that the Department clarify, either in the final rule or subsequent implementation guidance, that an otherwise qualified patient is not excluded from utilizing an approved location solely because the patient is participating in probation, parole, diversion, treatment court, specialty court, reentry, or another state or local community-supervision program, provided that the patient and location otherwise satisfy applicable statutory and regulatory requirements.

Conclusion

New Mexico has an opportunity to build a medical psilocybin program that is clinically rigorous, accessible, integrated with existing healthcare, and responsive to populations that have historically faced significant barriers to treatment.

As the Department finalizes 7.35.3 NMAC, I respectfully encourage it to preserve the transitional pathway for experienced clinicians, reconcile the 40-hour practicum provisions, provide clear guidance concerning justice-involved patients and confidentiality, preserve integration with existing behavioral healthcare, establish transparent staffing-waiver criteria, and protect meaningful access through other approved locations.

These clarifications would support patient safety while helping New Mexico develop a qualified workforce and an accessible continuum of care for individuals with substance use disorders and other qualifying conditions.

Thank you for the opportunity to provide public comment and for the Department's work implementing the Medical Psilocybin Act.

Respectfully,

Patricia Singh, PhD, LPCC
Owner & Executive Director
A New Awakening

Co-Founder
Trip HōM

New Mexico Licensed Professional Clinical Counselor
New Mexico Board-Approved Clinical Supervisor
Colorado Natural Medicine Facilitator & Handler

Dr. Patricia Singh, PhD, LPCC
A New Awakening, INC
400 Gold Ave SW Suite 1200
Albuquerque, NM 87102

This email and any files transmitted with it are confidential and are intended solely for the use of the individual or entity to which they are addressed. This communication may contain material protected by HIPAA legislation (45 CFR, Parts 160 & 164). If you are not the intended recipient or the person responsible for delivering this email to the intended recipient, be advised that you have received this email in error and that any use, dissemination, forwarding, printing or copying of this email is strictly prohibited. If you have received this email in error, please notify the sender by replying to this email and then delete the email from your computer.

PUBLIC COMMENT ON NMAC 7.35.3

This public comment is submitted jointly by Healing Advocacy, Psychedelic Mental Health Access Alliance, and Rudick Law Group in response to draft rules. Our public comment focuses on features of the draft rules that are likely to unnecessarily limit patient access, complicate insurance coverage, drive up patient cost, and unnecessarily inflate departmental regulatory and administrative burden, raising program costs to the state. We are committed to the success of the state program, and are committed to being collaborative partners and resources throughout rulemaking and implementation.

I. Significant Program Design Concerns: Certifying Clinician, Patient Application, Supervision Structures

The draft rules contain significant design concerns that threaten to impact patient access and the long-term viability of the state program.

A. Certifying Clinician Design Exceeds Statute and Misunderstands Safety in Psychedelic-Assisted Therapy

We continue to warn against the proposed certifying clinician design. The proposed certifying clinician design misunderstands the safety requirements of this program and requires redress if New Mexico intends to build a safe and accessible program.

The design choice would require any patient who is seeking psilocybin care to be seen by a specially-permitted DOH prescribing clinician provider in an in-person encounter with limited exceptions for telehealth. As the Department has explained in public meetings, the design tracks the state's medical cannabis program, and the regulations read almost identically to those for "practitioners" in the medical cannabis program. The statute governing medical cannabis specifically required a prescribing clinician to assess a patient for the medical appropriateness of cannabis. No such requirement is present in the Medical Psilocybin Act, which carries the following two definitions:

"clinician" means an approved health care provider licensed in New Mexico who holds a permit from the department to provide medical services to qualified patients

"qualified patient" means a patient whose clinician has judged the patient to be a medically appropriate candidate for the use of medical psilocybin based on being diagnosed with a qualifying condition

Read together, these definitions create the legal parameters for patient entry in the Medical Psilocybin Program. All that is required under the statute is a qualifying condition, which can be confirmed by any licensed healthcare provider in New Mexico with authority to diagnose and treat these conditions. The certifying clinician design greatly exceeds this statutory framework.

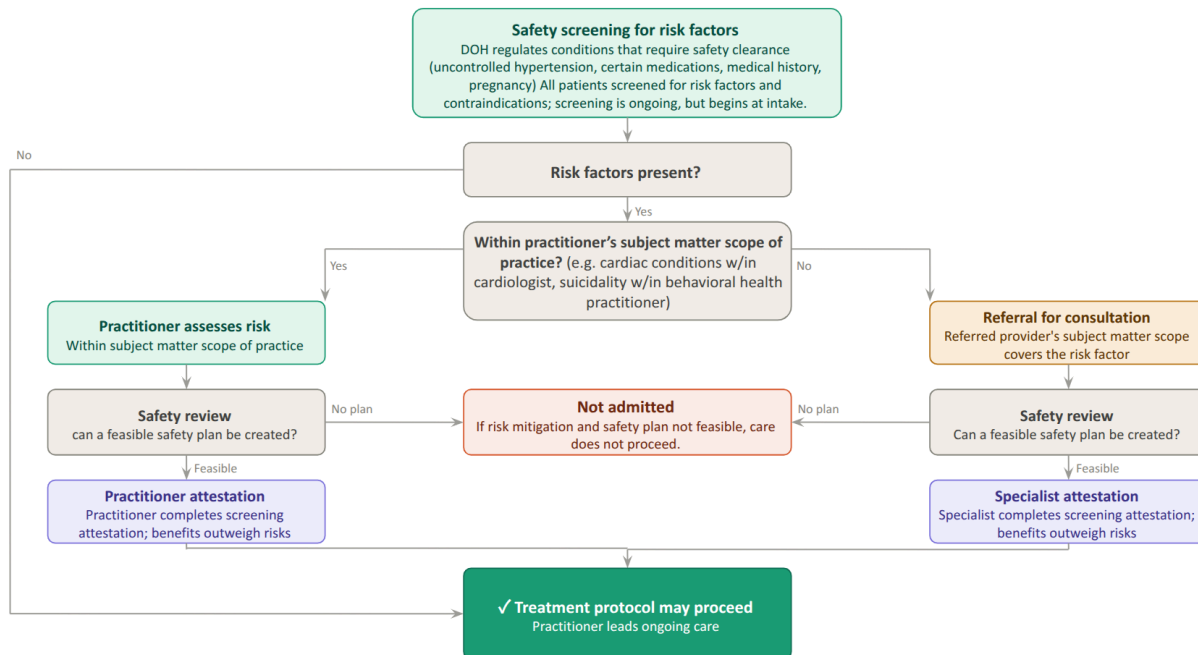
Health and safety screenings are important to building a safe program and should be regulated by the Department, but the certifying clinician design misunderstands how true medical concerns and safety risks present in a context of psilocybin-assisted therapy. By delegating safety and health screening to a prescribing provider gateway mechanism, the program assumes that risks will primarily be static (not changing over the course of treatment) and pharmacological, but this is far from true. The most significant risk factors in psilocybin-assisted therapy are psychological in nature and medical risks that require screening the day of administration (e.g. pregnancy, intoxication). These are missed in a safety system that assumes prescriptive authority upon entry equals medical safety.

In a safe psilocybin treatment model, safety screenings are ongoing, are conducted by the team most closely relating to the patient throughout their preparation, and are assessed by clinicians whose subject matter scope of practice aligns with the particular risk. Where that necessary expertise is not held by the primary care team, expert referrals and consultations are made to clinicians with appropriate expertise before treatment continues.

We recommend the Department remove the certifying clinician design. Many patients with qualifying conditions will not have contraindications, and rather than the blanket certifying-clinician model of Medical Cannabis, the Department should regulate around specific contraindications, medical histories, and medications that warrant clinical review (e.g. certain medication interactions, uncontrolled hypertension, history of psychosis, etc).

Where a risk factor is identified, the Department can require a clinician attestation that screening was conducted and that benefits outweigh risks. Such additionally required health screening should be conducted by a clinician whose subject matter scope of practice fits the patient's individual risk. The need for referral to conduct the risk factor follow up and assessment follows the practitioner's existing medical license: where a risk factor falls within the facilitator's subject matter scope of practice, the facilitator may proceed. Where it exceeds that scope, referral to a clinician whose license covers the relevant clinical area is required.

This model directs specialized review to patients who need it without imposing a universal requirement on program entry. The model would function as diagramed on the next page:



Additionally, the Department should consider requiring same-day pregnancy and drug testing. Poly-intoxication and unknown pregnancy status are commonly observed risks across many forms of psychedelic-assisted therapy, and the complications arising from both are preventable by a simple urinalysis.

In discussion, the Department has objected to this proposed revision on the grounds that it relies on patient attestation of health history rather than a medical exam. We share patient safety as our top priority. Our recommended protocol is based on the objective assessment of psilocybin's physiological risk profile, which is extremely low. The relevant medical risks are drug interactions — screenings for which already rely on patient attestation, regardless of who administers the screening – and hypertension, a condition for which any practitioner or facilitator can be trained to screen. Psilocybin's behavioral health contraindications (e.g. suicidality, personal or family histories of psychotic disorders or bipolar disorder) are conditions for which screening already relies on patient attestation. Consequently, appropriate and necessary health and safety screenings can be carried out without creating the barrier of the program's prescriber-gateway design.

If the Department remains unwilling to consider an alternative design, we want to further recommend strategic targeting of the limited provider base that will be able to fill this entry point role. In addition to targeting the Medical Doctors, Nurse Practitioners, Psychiatrists and other traditional prescribing providers, we recommend that DOH target the additional healthcare provider types who have been giving prescriptive authority in New Mexico: naturopathic doctors, acupuncturists, and chiropractors. These provider types have been specifically targeted to expand primary care access in New Mexico in address our longstanding provider shortage. These are also providers who have unique holistic health training, which is well-suited for the

kind of dynamic, health screenings that are most effective to keeping patients safe under psychedelic care.

B. Patient Application Inappropriate in Supervised-Use Program

The patient application process in the draft rules is unnecessary and should be stricken.

This seems to be another place where the Department has chosen to adopt a provision from the medical cannabis program without analysis of whether it is appropriate in the unique context of psilocybin. The “patient identification card” structure of the state’s medical cannabis program arises from a framework in which authorized patients will possess for legal medical use what would otherwise (at the time the Act was passed) be an illegal substance. To handle this, the Lynn and Erin Compassionate Use Act directly created a patient application process and endowed the Department of Health with duty to develop a process for reviewing and approving or denying those applications.

The medical psilocybin program operates quite differently. Because it relies on a model of supervised administration in approved locations only, no patient will legally possess psilocybin outside of that supervised episode. Therefore, there is no scenario in which a psilocybin therapy patient will need to prove their authorization to possess psilocybin, and thus no need for patient identification cards or applications.

The decision to replicate this model will, inappropriately and without any legal or policy justification, introduce tremendous administrative burden for the Department, add additional patient care wait times, introduce additional potential for patient data to be accessed without consent or unlawfully exfiltrated, and further stigmatize psychedelic-assisted therapy patients. The application process should be stricken.

C. Liability Concerns Regarding Supervision Structure Between Practitioners and Facilitators

At various points, the draft regulations create supervisory relationships between permit-holders (for example, the supervision of facilitators by practitioners). Supervisory roles carry liability for the conduct of those supervised, and in a medically-integrated model this takes on particular significance. Where a facilitator is not a medical professional and is not otherwise subject to the Medical Malpractice Act, placing that facilitator under a practitioner’s supervision may inadvertently bring the facilitator’s conduct within the supervising practitioner’s malpractice exposure, while leaving the facilitator outside the coverage framework that would ordinarily accompany that exposure. The facilitator could effectively be subjected to the Act’s liability consequences without access to the malpractice coverage the Act provides. This asymmetry could undermine the program’s ability to build the integrated clinical workforce it requires.

D. Long Lead Liability Problems with these Design Features

The issues identified above carry long lead liability problems, problems that may take years to surface but that will ultimately bear on the program's long-term viability. The most significant of these involves third-party payers.

The certifying clinician role as designed creates substantial risk of claim denials and clawbacks. Because the role exists solely to facilitate entry into a psilocybin therapy program, the clinical encounter it creates lacks a clearly defensible basis for independent medical necessity, which is precisely the standard insurers apply when evaluating coverage. We recognize that HCA offered reassurances on this point during a summer Advisory Board meeting, and we appreciate that engagement. However, regulatory structures cannot be built around current agency leadership, interpretations, or directives that will inevitably change. A clinical encounter that exists to authorize participation in a Schedule I substance program, rather than to address an independent medical need, will invite scrutiny over time, and coverage counsel for both public and commercial payers will look to the regulations themselves for grounds to deny claims or pursue clawbacks. Commercial insurers in particular operate under different incentive structures than HCA and are likely to apply considerably more scrutiny.

This is a further reason the Department should adopt the alternative patient flow proposed above. For patients who already have a diagnosis and an established care team, the sole function of the certifying clinician encounter is program entry. Creating a mechanism for these individuals to proceed directly to the components of care with clear, independent medical necessity (safety screening, preparation therapy, and related service) protects both patients and the program's long-term financial viability.

The supervisory relationships the regulations create between clinically licensed practitioners and non-clinically licensed facilitators are likely to generate significant third-party payor problems beyond the malpractice exposure already described. The core issue is that services rendered by unlicensed or non-clinically credentialed individuals are generally not reimbursable by health insurance. With narrow exceptions (for example, chaplain services in hospice care under Medicare, certified peer support workers under New Mexico Medicaid) insurers do not reimburse services delivered by people who fall outside recognized billing taxonomies. Where a regulation creates a supervisory or assistive relationship between a clinician (practitioner) and a non-clinician (facilitator), a payor reviewing a claim may characterize services billed under the practitioner's credentials as having been delivered, in whole or in part, by someone not authorized to bill, exposing the practitioner to claim denial, clawbacks, or other more serious consequences such as fraud.

The solution is not to pretend that practitioners and facilitators do not work together. They do, and the regulations should reflect that clinical reality. The problem is regulatory language that places one within the formal supervisory authority of the other in ways that blur billing boundaries. We recommend the Department treat the roles of practitioners and facilitators as legally and professionally independent within the regulatory framework, while separately articulating the ways in which they may coordinate care. A coordination or collaboration model (in which practitioners and facilitators communicate about patient care without a formal supervisory relationship) preserves the clinical integration the program depends on without

creating the payor exposure that a supervisory structure produces. Clear role delineation in the regulations would also give practitioners a defensible basis for billing only for the services they personally render, protecting both providers and the program from downstream clawback risk.

II. Other Issues Impeding Access

A. Landlord Attestation for Other Approved Locations Should Not Apply to Patients Seeking Care in Their Home or in Residential Living

We are grateful that the Department has developed an approval process for “other approved locations” for treatment that happens outside of a licensed Healing Center. One requirement on that approval process should be clarified. An application for care occurring in an “other approved location” currently requires:

“Proof of ownership by the qualified patient or attending practitioner or facilitator of any property on which medical psilocybin administration sessions will be conducted, or a signed, written statement from the owner of such property acknowledging that the owner understands that persons will be participating in the medical psilocybin program on the premises, and what those persons are authorized to do within the terms of their certification.”

As written, this requirement applies to any property where an administration session occurs, including a patient’s own home. For end-of-life patients and other patients who receive in-home care and who rent rather than own their residence, the provision seems to require them to obtain a signed statement from their landlord acknowledging their participation in the Medical Psilocybin Program and describing what they are authorized to do under their certification, before they can receive care in their own home.

From Advisory Board meeting discussions of this provision, the Department has acknowledged that this is another feature borrowed from the medical cannabis program. Cannabis is typically smoked or vaporized, and a landlord has a real, practical interest in knowing whether that will occur on their property, given the potential effects on odor, ventilation, and property value. Medical psilocybin administration is a different clinical model and will happen only in a supervised session administered by a licensed facilitator, involving no smoking or lingering property effects of any kind. The property-owner interest that justifies the cannabis provision simply is not at all present in Medical Psilocybin.

The Department has suggested that – even though psilocybin is not a smoked drug – ongoing federal illegality alone justifies the required landlord’s permission. However, New Mexico already made the decision to depart from federal law, a calculated choice to put our state values above misguided federal judgment in recognition of the profound potential of psilocybin to facilitate healing. Granting landlords authority to impede the healing of vulnerable and disabled patients

is contrary to these values. For these reasons, Commenters endorse the revision recommended to the Department by End of Life Options New Mexico, copied here:

“This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents.”

Commenters note that failure to make these revisions is likely to expose the Department to liability under state law protections against discrimination. Similar litigation in Oregon on behalf of home-bound patients has already cost the Oregon Health Authority hundreds of thousands of dollars and is still ongoing.

III. Additional Safety Gaps

A. Minimum Hours Should be Assigned to Certain Didactic Topics

Commenters appreciate that the draft training requirements have seen significant improvement through the advisory board process and commend the Department for collaborating with subject matter experts to bring regulations closer to the educational and safety standards of the psychedelic field. However, two content areas also appear to be missing entirely: suicidality and challenging experiences. Given that treatment-resistant depression and PTSD are among the qualifying indications, these topics are key to ensure safety in the program.

We also recommend that certain content areas be assigned minimum hour requirements, to ensure that training programs deliver sufficient education on topics that are key to patient safety. We suggest the following minimum hours be assigned to the following topics:

- Suicidality screening and crisis response — 5 hours
- Challenging experiences, including de-escalation — 4 hours
- Pharmacology, drug interactions, and clinical research — 5 hours
- Trauma and trauma-informed care — 7 hours
- End-of-life care — 5 hours

Thank you for considering this feedback. We look forward to participating in the October 2, 2026 hearing and to offering any support we can to the Department in resolution of the above identified issues.



Multidisciplinary Association for Psychedelic Studies
3141 Stevens Creek Blvd, #40563
San Jose, CA 95117

September 20, 2026

To the New Mexico Department of Health:

My name is Sia Henry and I'm submitting this letter on behalf of the Multidisciplinary Association for Psychedelic Studies (MAPS). For nearly four decades, MAPS, a nonprofit research and educational organization, has been developing medical, legal, and cultural contexts for people to benefit from the careful use of psychedelics and cannabis across the country and world. Over the years, MAPS has developed an evidence-based, realistic, and honest assessment of the risks and potential of psychedelic substances. We have also worked with countless therapists, policymakers, regulators, advocates, and other stakeholders in the psychedelic space and are excited to support New Mexico as it continues to make history building out the country's first legislator-passed psychedelic-assisted healing program.

Along with the rest of the psychedelic community, MAPS celebrated New Mexico's historic passage of SB 219 in 2025, and again this spring when the Legislature made a substantial investment in treatment funding for low-income New Mexicans. New Mexico now has the opportunity to lead the country with the first regulated program tied to an existing state healthcare system, with an explicit focus on access. Given this significant opportunity, we write to raise concerns about the current direction of the program. While the medical nature of New Mexico's legal model is explicit in statute, the proposed regulations go well beyond that statute, over-medicalizing and over-complicating the provision of psychedelic care and prioritizing property owner rights over the rights of patients. This runs counter to established standards of psychedelic care and to the values that we celebrated instilled in the acts of the Legislature. We urge reconsideration of this approach and recommend certain revisions.

First, the design of the certifying clinician requirement exceeds what the statute requires, over-medicalizing the delivery of care and departing from the values and standards long established in this and other psychedelic medicine. The design would compel any patient seeking psilocybin-assisted therapy to first see a prescribing provider, in person (with only narrow exceptions). The requirement includes no exception for patients who already have a qualifying diagnosis. The statute specifically defines "qualified patient" as "a patient whose clinician has judged the patient to be a medically appropriate candidate for the use of medical psilocybin



based on being diagnosed with a qualifying condition.” This language specifically ties patient entry to the qualifying medical condition alone. Furthermore, the statute defines “an **approved health care provider** licensed in New Mexico who holds a permit from the department to provide medical services to qualified patients.”

The Department has implemented these two provisions with excessive conservatism, a choice that will have long-term consequences for public trust in the program and for the efficacy of the care it delivers. We caution against this approach. Colorado’s state program offers a useful comparison: its clinical facilitator track has operated with strong patient safety outcomes by matching health screening to each patient’s individual needs and risks. Dually licensed facilitators work within their scope of practice to screen for health risks, consulting and referring out to more specialized practitioners when necessary. This model is both patient-centered and clinically appropriate. The proposed certifying clinician design is neither.

Second, the patient application structure mirrors the medical cannabis model, but is unnecessary and unjustified in a supervised-use setting. As designed, a provider must submit patient health information to the Department of Health for review, approval, or denial within 30 days of submission. This process increases administrative burden on providers, which can drive up costs, and burden on patients, which can discourage people from seeking care. Medical cannabis required a card system (and associated application) to protect patients from adverse law enforcement encounters in public. Supervised, private psilocybin use presents no comparable justification, making this patient application process unnecessary.

Finally, MAPS is deeply concerned about the proposed requirement that renter-patients seeking care in their homes obtain written landlord approval. No such requirement exists in Colorado, and were one imposed there, patients would likely be unable to access care in their own homes unless they owned the property. The provision exposes renters to stigma and discrimination and forces private medical disclosure to their landlord. We respectfully request that an exemption be drafted for patient-renters.

Sincerely,

Sia Henry

Associate Director of Policy & Advocacy, MAPS

sia@maps.org

917-324-7814

To: New Mexico Department of Health

Re: Public Comment on NMAC 7.35.3, Medical Psilocybin Program Rules

From: Anne L. Metz, PhD, LPCC

Date: September 22, 2026

I am a licensed professional counselor in New Mexico and a resident of Taos County. I am a licensed Natural Medicine Facilitator in Colorado and Director of an Approved Facilitator Training Program there, with a background in risk assessment research and clinical facilitation experience under Colorado's regulated psilocybin program. I submit the following comments on the draft rules.

1. The certifying clinician model treats risk as a fixed, one-time determination, when clinical risk is dynamic

My prior published research on risk assessment in criminal sentencing centered on a core finding that also applies here: risk is not a fixed trait established at a single point of contact, it is a probability that shifts with new information over time. Treating a certifying clinician's one-time, pre-treatment clearance as the safety mechanism for the whole course of care builds the same error into this program that risk-assessment research has spent decades correcting in other fields.

The risks most relevant to psilocybin-assisted therapy — psychological readiness, same-day contraindications such as pregnancy or intoxication, a patient's state on the day of administration — are not visible at intake and cannot be cleared in advance. The practitioner who is actually with the patient through preparation is in the better position to identify and respond to risk as it develops, referring out for medical consultation only where a specific factor (certain medications, uncontrolled hypertension, a psychotic disorder history) falls outside their own scope of practice. Requiring every patient to clear a separate certifying clinician encounter before treatment can begin, regardless of whether any risk factor is present, does not make the program safer; it substitutes a single checkpoint for the ongoing clinical judgment that actually manages risk, and adds cost and delay for patients who have no risk factors at all. In rural counties where a certifying clinician may not be reasonably available, it may foreclose access to care entirely.

2. The patient application places the greatest burden on the patients least able to carry it

A state-level patient application adds a procedural step between diagnosis and care. That step is not neutral in its effect: it falls hardest on the rural, elderly, disabled, and low-income patients this program is meant to serve — people who may lack reliable internet access, transportation to submit paperwork in person, or the time to navigate an additional bureaucratic process on top of managing a serious psychiatric condition. A patient with treatment-resistant depression or a terminal diagnosis is the patient least equipped to absorb delay. Given that psilocybin is administered only in supervised sessions and a patient never possesses it outside that setting, the application does not serve a possession-authorization purpose the way it does in New Mexico's medical cannabis program. It functions only as an access barrier, and should be removed.

3. A 2:1 facilitator ratio is unworkable given New Mexico's existing behavioral health workforce shortage

New Mexico already has some of the most severe behavioral health workforce shortages in the country, particularly outside Albuquerque and Santa Fe. Oregon requires no more than a single facilitator for standard individual sessions, scaling to lower ratios only for high-dose group administration. Colorado sets no comparable ratio requirement for individual sessions at all. A 2:1 requirement does not just raise the cost of an individual session; in a rural county with one or two behavioral health providers total, it may make it functionally impossible to staff a session at all. This provision should be reconsidered with New Mexico's actual provider distribution in mind, not modeled on assumptions about staffing availability that do not hold outside urban areas.

4. Landlord permission introduces friction into the patient's home that no other form of home-based clinical care requires

Home health, hospice, and in-home mental health treatment are all delivered routinely in patients' rented homes without requiring landlord sign-off, because the presence of a clinician providing care is not treated as a property concern. As written, the "other approved locations" provision would require a renting end-of-life or homebound patient to obtain a signed statement from their landlord before receiving psilocybin therapy in their own home — a requirement with no counterpart anywhere else in New Mexico's behavioral health system, and one that risks delaying or blocking care for exactly the patients least able to travel to a healing center. I support revising this provision so it does not apply to end-of-life patients, other patients receiving in-home care, or long-term care facility residents.

5. Cumulative effect on clinician participation

Taken together, these provisions raise the cost, staffing burden, and administrative overhead of participating in New Mexico's program well above what Oregon's or Colorado's programs require. The more likely outcome is that clinicians decline to take regulated-access patients and instead limit their practice to FDA-approved synthetic psychedelics once available, bypassing the state program entirely. This leaves the majority of New Mexicans who would seek treatment through the regulated program without a clinician willing to see them.

I look forward to participating in the October 2, 2026 hearing and am glad to provide additional detail on any of the points above.

Respectfully submitted,

Anne L. Metz, PhD, LPCC

From: [Gina Knepell](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Thursday, September 24, 2026 7:40:49 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I want this program to be a safe and genuinely supportive resource for NM residents in need of psilocybin treatment.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Add to paragraph (B)(9) of 7.35.3.11: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Gina Devani
 Santa Fe, New Mexico

From: [Catherine Warnock](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment 7.35.3 NMAC hearing Oct 2, 2026
Date: Thursday, September 24, 2026 8:10:59 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Las Cruces, a licensed professional counselor, and an experienced psilocybin-assisted therapy practitioner and educator. I am submitting these comments regarding proposed Rule 7.35.3 NMAC in advance of the October 2, 2026 hearing.

I strongly support the development of a safe and responsible Medical Psilocybin Program in New Mexico. However, safety cannot be considered independently from **access and affordability**. A program can exist on paper and still fail the people it was created to serve if the regulatory structure makes treatment too expensive, complicated, or difficult to access.

I am particularly concerned about the cumulative effect of multiple requirements. Each additional appointment, professional, approval, document, and administrative step adds cost and creates another potential point at which a patient may be unable to proceed.

These burdens will not fall equally on all New Mexicans. They will disproportionately affect people with limited financial resources, rural residents, people without established medical providers, renters, and communities that already experience barriers to conventional healthcare.

I respectfully ask the Department to reconsider the following three provisions before adoption of the final rule.

1. Certifying Clinician, 7.35.3.8 and 7.35.3.9(D)

Recommendation: Replace universal certifying-clinician clearance with risk-based medical review.

I strongly support appropriate medical screening. I do not believe every patient should automatically be required to undergo a separate medical gatekeeping process regardless of their individual risk profile.

Instead, the rules should identify the specific medical histories, contraindications, medications, and other risk factors that require additional clinical review.

When one of those factors is identified during standardized screening, the patient could then be referred to a clinician whose scope of practice is appropriate to that particular concern. That clinician could attest that the relevant risk was evaluated and that the anticipated benefits of treatment outweigh the identified risks.

This would create a **risk-based model rather than a universal medical-clearance model.**

Universal certification creates an additional clinical encounter whose primary purpose is gaining entry into the psilocybin program. For patients without an established clinician, this may mean locating another provider, scheduling another appointment, paying another fee, obtaining an in-person examination, and transferring records before treatment can even begin.

For uninsured and underinsured New Mexicans, those requirements may be prohibitive. For rural New Mexicans, access to an appropriate clinician may itself be difficult. Insurance coverage for an encounter conducted primarily to satisfy a regulatory requirement may also be uncertain, potentially shifting the cost directly to the patient.

The requirement may also create a bottleneck by making every patient dependent upon a limited pool of certifying clinicians.

New Mexico has repeatedly expressed an interest in creating a program that is more accessible and affordable. We should be cautious about building a highly medicalized gateway that increases cost and delay when medical consultation could instead be targeted to the patients who actually need it.

A risk-based approach does not reduce safety. **It directs medical resources toward the risks that actually require medical expertise.**

2. Patient Application Process, 7.35.3.8

Recommendation: Eliminate the individual patient application and state approval process.

I also ask the Department to reconsider why individual patients must apply to the state for permission to participate in a supervised medical psilocybin program.

The proposed process adds another administrative layer between a qualified patient and treatment. It requires patients to submit sensitive information to the state and then wait for Department approval before proceeding.

This creates several concerns.

First, it delays care. Under the proposed rule, the Department may take up to **30 calendar days** to act on a completed patient application. NMAC-7.35.3-NewRule

Second, it increases administrative burden for both patients and the Department. Resources devoted to processing individual patient applications could instead be directed toward provider oversight, program quality, safety monitoring, and enforcement.

Third, it creates an additional repository of sensitive patient information. Every unnecessary collection of health information creates another privacy and data-security exposure.

Finally, requiring patients to register with the government before receiving treatment may reinforce stigma around both psychedelic treatment and the conditions for which patients are seeking care.

If eligibility can be appropriately established and documented by regulated professionals, it is

unclear what additional patient-safety function is achieved by requiring separate state approval of every individual patient.

3. Property-Owner Statement, 7.35.3.11(B)(9)

Recommendation: Delete Paragraph 7.35.3.11(B)(9).

Requiring written acknowledgment from a property owner creates a significant and unnecessary barrier to receiving treatment at a patient's residence.

The landlord interest that may justify similar requirements in cannabis programs, particularly smoking or cultivation on rental property, is not present in a supervised psilocybin administration session. Psilocybin is administered to a patient under regulated conditions. The property itself is not being used to manufacture, cultivate, or store a controlled substance on an ongoing basis.

From the property owner's perspective, there may be little incentive to sign such an acknowledgment and considerable perceived reason not to. A landlord who does not understand psilocybin treatment, is concerned about liability, or simply does not want involvement can refuse to sign.

The result is that **home-based treatment becomes available to homeowners but potentially unavailable to renters.**

That creates an inequitable distinction based not on patient safety, medical risk, or practitioner competency, but on property ownership.

This could particularly affect lower-income patients, people with disabilities, rural residents, older adults, and others for whom receiving treatment at home may be the most accessible option.

If the Department believes that property-owner interests require protection, I encourage it to consider a less restrictive alternative that does not give a third party effective veto authority over a patient's healthcare.

The Larger Concern: Affordability and Access Must Be Built Into the Program

These three provisions illustrate a larger concern.

When regulatory requirements are considered individually, each may appear reasonable. The problem becomes clearer when they are considered **cumulatively**.

A patient may need a recent medical examination, a certifying clinician, state enrollment and approval, an approved treatment location, and multiple professionals before receiving treatment. Each requirement adds another cost, delay, and potential barrier.

Those burdens will disproportionately affect the New Mexicans who already have the greatest difficulty accessing healthcare.

An Equity and Access Fund is valuable, but **equity should be built into the regulatory structure itself**. Subsidizing an unnecessarily expensive system is not the same as designing an affordable one.

New Mexico has an opportunity to create a program that protects patients without creating unnecessary barriers to the treatment the program was established to provide.

I encourage the Department to evaluate each proposed requirement by asking:

What specific risk does this requirement address? Is it necessary for every patient? Is there a less burdensome way to achieve the same safety objective? And what will this requirement ultimately cost the patient?

Safety, affordability, and accessibility are not competing goals. A thoughtful regulatory framework can accomplish all three.

I respectfully ask the Department to adopt a risk-based approach that protects patients while removing requirements that do not meaningfully improve safety. Doing so will help ensure that New Mexico's Medical Psilocybin Program is not merely available, but **actually accessible to the New Mexicans it was created to serve**.

Thank you for considering my comments and for the work being done to develop this program.

-Catherine

Catherine Warnock, MA, LPCC, NCC (she/her)

Mariposa Counseling Center

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From: [Andrea Ensign](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Psilocybin proposed rules
Date: Thursday, September 24, 2026 8:57:14 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Albuquerque, and I am also a clinician. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I am a clinical provider, PMHNP, and concerned about the property-owner statement. I am concerned that landlords will not be informed about the clinical efficacy and safety and will automatically refuse access to their properties.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Andrea Ensign
Albuquerque, New Mexico

From: [Brooke Kaemingk](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Thursday, September 24, 2026 10:53:19 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe, and I am also a renter and hospice RN MSN. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I work in end of life with the people/patients that will be affected by this new legislation.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time “prescriber” gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Brooke Kaemingk
Santa Fe, New Mexico

From: [Candace Sandoval](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Thursday, September 24, 2026 1:36:57 PM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa fe. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Add to paragraph (B)(9) of 7.35.3.11: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Candace Johnson
Santa fe, New Mexico

Sent from my iPhone

From: [Brandon Johnson](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Wednesday, September 23, 2026 7:34:41 PM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe, and I am also a renter. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

Our community deserves access to this medicine and support.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Add to paragraph (B)(9) of 7.35.3.11: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Brandon Johnson
Santa Fe, New Mexico

Sent from my iPhone

From: [Soma Franks](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Wednesday, September 23, 2026 7:34:17 PM

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To the New Mexico Department of Health: I am a New Mexico resident in Santa Fe. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing. I am currently pursuing my masters degree in counseling with the goal of working with end of life issues. Psilocybin assisted therapy shows great promise in this regard. I ask the department to make the following changes in the final rule. 1. The property-owner statement, 7.35.3.11(B)(9). I ask the department to consider these solutions: a) Add to paragraph (B)(9) of [7.35.3.11](#): "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents." b) Delete paragraph (B)(9) of 7.35.3.11. The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment. 2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D). Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks. The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks. 3. The patient application, 7.35.3.8. Strike the patient application process. It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients. Thank you for considering my comment. Soma Franks Santa Fe, New Mexico

From: [Allana Pratt](#)
To: [Clark, Jacob, DOH](#)
Cc: [Allana Pratt](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Wednesday, September 23, 2026 4:38:56 PM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I choose legalization of psychedelics to address the mental health crisis, with effective support in emotional processing, trauma integration, collective awakening and spiritual growth.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Add to paragraph (B)(9) of 7.35.3.11: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Alana Pratt

Santa Fe, New Mexico

To the New Mexico Department of Health:

I am a Marine Corps veteran and a New Mexico resident living in Albuquerque. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

New Mexico has high rates of suicide, particularly among veterans and first responders. Psychedelic access is suicide prevention, but only if people can reach the program.

I ask the department to make the following changes in the final rule.

1. The certifying clinician, 7.35.3.8 and 7.35.3.9(D)

I ask the department to consider these solutions:

a) Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation, from a clinician whose scope of practice fits that risk, that screening was conducted and benefits outweigh risks. Allow the patient's own treating provider to serve that role.

b) At minimum, delete the controlled substance number requirement at 7.35.3.9(D)(2), so that any New Mexico provider licensed to diagnose the qualifying condition may certify.

This is how both operating state programs work. Screening happens inside the care relationship, and referral follows when a risk exceeds the provider's scope, the same way it does everywhere else in medicine.

The design misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time prescriber gateway misses them. It also goes stale. The in-person exam behind a certification may already be six months old (7.35.3.13(A)), and enrollment then lasts two years (7.35.3.8(E)). A patient could be dosed on the strength of a physical exam up to two and a half years old, signed by a clinician who has not seen them since. The practitioner who sees the patient the week of the session has no role at entry.

The gate also degrades the screening it exists to perform. Full disclosure is not the default when someone is clearing a gate. A patient who must satisfy a stranger has every reason to leave things out. Disclosure is more complete inside an ongoing relationship with the providers who will actually be in the room.

The credential is the wrong proxy. The certifying clinician completes eight hours of psilocybin training (7.35.3.18(B)). Practitioners and facilitators complete at least 70

didactic hours, 10 hours of simulated patient experience, and 100 to 120 practicum hours (7.35.3.18(C) through (E); 7.35.3.19), covering drug interactions, pharmacology, and psychedelic emergencies. The certifying module even includes education on diagnosing the qualifying conditions (7.35.3.18(B)(4)), which is the core scope of the licensed counselors and social workers this rule excludes. Under 7.35.3.9(E) and 7.35.3.14(A), a licensed counselor or clinical social worker may be the practitioner who administers psilocybin and manages the entire session. That same provider may not certify the patient.

The design exceeds the Act. The Act defines a clinician as a New Mexico licensed health care provider permitted by the department to provide medical services, meaning preparation, administration, and integration (26-2D-3(B) and (D)). A qualified patient is one "whose clinician has judged" them to be a medically appropriate candidate based on a diagnosis of a qualifying condition (26-2D-3(H)). That judgment belongs to the clinician who provides the patient's care. Nothing in the Act requires prescriptive authority, and the Legislature removed psilocybin from the state's Schedule I for this use (30-31-6(E)). The rule instead requires a controlled substance registration from a clinician who provides none of the medical services the Act describes.

Few prescribers will accept the role. The certifying clinician is the first signature in the chain of liability. For the next two years the patient may work with any certified team at any location, and the certifying clinician does not choose that team, supervise it, or see the patient again. There is no established standard of care for psilocybin services, and many malpractice carriers exclude federally illegal activity. That is liability without authority, in a state where 32 of 33 counties are federally designated Health Professional Shortage Areas. A safety requirement that qualified providers decline to perform is an empty chair at the front of the program. Veterans are hit hardest. VA providers are federal employees and cannot certify, so a veteran whose care has always run through the VA starts from nothing.

The entry encounter is unlikely to be covered. It is a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks. The adjacent program bears this out. In a survey our team conducted this summer of the medical cannabis certification market, no provider in New Mexico could be confirmed to bill any insurer for a certification visit, and certification businesses are not enrolled Medicaid providers. The Act seats a Health Care Authority representative on the advisory board (26-2D-8(A)), a sign that coverage was part of the design. A cash-only front door defeats it.

2. The patient application, 7.35.3.8

I ask the department to consider these solutions:

- a) Strike the patient application process.

b) At minimum, make enrollment effective when the clinician's certification is filed, with the department retaining its authority to audit, investigate, and act on problems after the fact.

The department should be a recipient of program information, not the arbiter of admission.

The Act does not call for it. A qualified patient is defined by the clinician's judgment alone (26-2D-3(H)), and the Act's protections attach to that status (26-2D-5). The Lynn and Erin Compassionate Use Act was built around a state-issued registry identification card. The Legislature did not build this program that way.

The cannabis rationale does not carry over. The cannabis registry rules state that their requirements exist so the state can distinguish authorized use from unauthorized use under its criminal laws (7.34.3.2 NMAC). That makes sense for a substance patients possess and use at home. Under these rules psilocybin may only be consumed at a certified location (7.35.3.20(C)), in a supervised session, tracked by chain of custody (7.35.3.14(D)). There is nothing left for a patient registry to distinguish.

The information already reaches the department. Practitioners and facilitators report dates of service, administration, product identification, dosage, integration, and adverse events (7.35.3.13(C)). Healing centers and other approved locations keep patient lists and daily logs in the department's system (7.35.3.20(A) and (E)) and report adverse events within two days (7.35.3.20(M)). Data collection under the Act (26-2D-9) does not require an approval gate.

It lengthens the wait for care. After a licensed clinician has made a professional judgment, the department reserves up to thirty days to approve or deny admission (7.35.3.8(C)). The department has not examined the patient and holds no clinical information the clinician lacks. There is no expedited path, and end-of-life care is a qualifying condition. Enrollment then expires after two years and the process repeats (7.35.3.8(E)).

It creates a store of sensitive data the program does not need. The application collects a copy of photo identification, full contact information, and a signed release of medical information (7.35.3.8(A)), and allows the department to contact clinicians and review medical records (7.35.3.8(C)(2)). The result is a single database linking named individuals to diagnoses of PTSD, depression, substance use disorder, and terminal illness, tied to a substance that remains federally illegal. That database can be breached, or reached by legal process, without the patient's consent. The Act points the other way. It requires that program data be reported so no individual patient can be identified (26-2D-9), and it treats condition petitions as confidential personal health information (26-2D-8(B)(3)).

It further stigmatizes patients. Requiring people with PTSD, depression, or a substance use disorder to register with the state before they may receive care treats that care as something to be permitted rather than provided. Behavioral health care is health care.

It also burdens the department, which must review every application within thirty days, handle informal reviews and appeals, and process re-enrollment every two years, time better spent overseeing providers and locations.

3. The property-owner statement, 7.35.3.11(B)(9)

I ask the department to consider these solutions:

a) Add to paragraph (B)(9) of 7.35.3.11: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

b) Delete paragraph (B)(9) of 7.35.3.11.

Other approved locations exist for the patients who cannot reach a healing center: those who cannot be physically transported, those with other medical necessity, and those in rural and frontier counties (7.35.3.11(B)). This requirement falls hardest on exactly those patients.

The landlord interests that justify restrictions on cannabis, such as smoke, odor, residue, fire risk, and home cultivation, are not present in a supervised psilocybin session. Nothing is burned, nothing is grown, and certified providers are present throughout. Federal illegality alone does not justify it either. New Mexico has already chosen to depart from federal law on this (30-31-6(E); 26-2D-5). Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and invites challenge under state protections against disability discrimination.

The provision also inverts the default. Property owners can already restrict conduct on their property. This rule requires their written sign-off in advance, so an owner who simply does not respond has blocked care. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

The statement is itself a disclosure. It tells the person who controls a patient's housing that the patient is in a program limited to people with PTSD, depression, substance use disorder, or a terminal illness. That disclosure alone can put a tenancy at risk.

For some patients, asking is dangerous. The Act requires the department's annual assessment to consider the needs of patients living in federal subsidized housing (26-2D-9). Landlords of federally assisted housing operate under federal rules that treat

illegal drug use, including use permitted under state law, as grounds to deny or end tenancy. For those patients, requesting the signature may put their housing at risk.

Long-term care facilities will not sign. A nursing home or assisted living facility that depends on Medicare and Medicaid certification has every reason to refuse, and its residents, many near the end of life, often have no practical way to reach a healing center.

Thank you for considering my comment.

Chris Peskuski
Albuquerque, New Mexico

On Sep 25, 2026, at 8:30 AM, Julian Joy <julianjoy@bearingmovement.com> wrote:

Dear Mr. Clark:

MycoVita is a founder-operated, software-enabled telehealth and patient-access company preparing to serve New Mexico patients under the Medical Psilocybin Act. We intend to provide patient education, enrollment navigation, telemedicine scheduling and intake, documentation and HIPAA-compliant record hand-off for independent, New Mexico-licensed certifying clinicians and permitted providers. We do not produce, possess or administer psilocybin, and we do not exercise clinical judgment. We support the Department's revised proposed rule and submit the following requests, each directed at text the published record does not yet contain.

1. Telemedicine certification (7.35.3.13(A)(2) and 7.35.3.8(B)(8)). We ask that the three telemedicine branches — in-person examination by the certifying clinician within six months; telemedicine evaluation with review of diagnosis records from a clinician who examined the patient in person within six months; or telemedicine evaluation with a formal consultation with that clinician — be adopted as published. New Mexico's qualifying-condition population is dispersed across rural and frontier counties, and this provision is what makes a statewide, rather than clinic-radius, certification pathway possible. We also ask the Department to state in the rule or in guidance what documentation of the 'formal consultation' under branch (iii) is expected in the clinician's submission.
2. Controlled-substance number (7.35.3.9(D)(2); 7.35.3.8(B)(3); amended definition in 7.35.2.7). Because a certifying clinician never prescribes or dispenses psilocybin, we ask the Department to state the purpose the New Mexico controlled-substance registration serves for this role, and to consider accepting either a controlled-substance registration or a Drug Enforcement Administration registration, so that qualified diagnosing clinicians who do not maintain a state CS registration are not excluded from the initial clinician pool.
3. The designated electronic system (7.35.3.8, 7.35.3.9, 7.35.3.13(C), 7.35.3.20). We ask the Department to publish, before the clinician application window opens, a technical description of the electronic system: submission formats; whether a certifying clinician may authorize a HIPAA business associate to prepare and upload submissions that the clinician reviews and signs; and whether machine-to-machine submission will be supported. Platforms that assemble documents for clinicians need this to build compliant workflows rather than manual re-keying.
4. Application window and timing (7.35.3.9). The rule fixes renewal timing and a 30-day decision clock but not the initial window. We ask the Department to publish the date, or the interval after adoption, on which certifying-clinician, practitioner, facilitator, healing-center and educational-program applications will be accepted, separately for each category, and to publish the New Mexico educational module and the certifying-clinician module (7.35.3.18(A)–(B)) or the list of approved providers of them at the same time, since completion of both is a precondition to applying.
5. Preparation and integration sessions. We ask the Department to state whether preparation and integration sessions may be delivered by telehealth in an 'approved setting', or whether only administration sessions must occur at a healing center or other approved location.
6. Fee transparency and referral compensation (7.35.3.11(A)(19)). We support the fee-disclosure requirement and ask the Department to add an express prohibition on compensated patient referrals and fee splitting within the program rules,

reaching non-clinician participants who are outside the Medical Practice Act, so that all participants operate under one standard.

7. Record retention, minimum age and equity-fund eligibility. We ask the Department to state retention periods for enrollment, certification, session and consent records rather than requiring a plan without a period; to state the minimum patient age or the consent architecture for minors; and to publish equity-fund income thresholds, documentation standards and the disbursement path.
8. Fees. We ask the Department to state whether any application, certification, renewal or enrollment fee will be charged, so that providers can price services and disclose fees to patients accurately.

We appreciate the Department's work and the Advisory Board's deliberations, and we are available to demonstrate our proposed telemedicine certification and enrollment-navigation workflow to program staff at the Department's convenience.

Respectfully submitted,

Julian Joy Co-founder, MycoVita www.mycovitalife.com

<MycoVita_Written_Comment_7.35.3_NMAC_2026-10-01_DRAFT.pdf>

From: [Danielle Leonard](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed rule 7.35.3 NMAC – Danielle Leonard, LMHC
Date: Friday, September 25, 2026 9:35:14 AM

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To the New Mexico Department of Health

Re: Public comment on proposed rule 7.35.3 NMAC, hearing of October 2, 2026

I am a New Mexico resident commenting on the certifying clinician provisions in 7.35.3.8 and 7.35.3.9(D). As a licensed mental health clinician, I urge the department to place entry decisions with the clinicians best trained to diagnose mental health conditions, rather than defaulting to prescribers.

The rule confuses prescribing authority with diagnostic competency. The proposed rule requires every patient to see a DOH-permitted clinician with a controlled-substance registration before entering the program. This design comes from the medical cannabis statute, which required it. The Medical Psilocybin Act does not. It requires only a qualifying condition confirmed by a New Mexico licensed provider with authority to diagnose and treat it. The programs are also different in kind. Medical cannabis serves a broad range of medical conditions, while psilocybin therapy is a mental health intervention for specific conditions such as treatment-resistant depression, PTSD, and substance use disorders.

The certifying judgment should rest with clinicians trained to assess those conditions. A DEA number shows that a clinician can prescribe. It says nothing about training in diagnosing treatment-resistant depression, PTSD, or alcohol use disorder. Many of the clinicians best trained in diagnosis, including psychologists and psychotherapists from APA- and MPCAC-accredited programs, do not prescribe, yet their training covers psychopathology, differential diagnosis, structured assessment, neuroscience, and psychopharmacology. Research shows diagnostic reliability depends heavily on this kind of training (Osório et al., 2019; Nordgaard et al., 2012; Kvig et al., 2023).

Entry decisions call for clinical judgment. Whether a person has a qualifying condition, and whether they are ready to begin, are separate questions that depend on their full clinical picture. For instance, someone with co-occurring symptoms may still be a good candidate, while someone with a clear qualifying condition may not yet be ready. These judgments belong with the clinician who has assessed the person and can decide when they are ready and how much preparation would help. A one-time visit with a prescriber who may have no ongoing relationship with the client, and whose mental health training may have been limited to a brief rotation during medical school, adds a step without adding that judgment.

An extra gateway adds burden without adding safety. Requiring an additional in-person visit with a separately permitted prescriber adds cost, delay, and travel, especially in rural parts of the state where such clinicians are already scarce, without adding a meaningful safeguard. In fact, a diagnosis from a clinician without specialized training in mental health is less reliable, and therefore less safe, than one from a clinician who has that training.

I ask the department to:

1. Remove the certifying clinician requirement and follow the Act, allowing any licensed New Mexico provider with authority to diagnose and treat a qualifying condition to confirm it.
2. Recognize that the diagnosing clinician's judgment governs whether a qualifying condition is present, when a client is ready, and how much preparation is beneficial.
3. Allow that clinician to consult with an appropriate medical provider when medical or medication questions fall outside their scope, as mental health clinicians are trained to do and routinely do for clients on medication.

Thank you for considering my comment.

Danielle Leonard LMHC
Santa Fe, New Mexico

From: [Deru You](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Friday, September 25, 2026 10:00:05 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Silver city. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I know that for certain severe mental health conditions, psilocybin can provide relief when all other avenues have failed. Especially for those at risk of suicide, this can literally be life-saving. It is extremely important that people who need it are able to access this medicine and get the help they need.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Deru Youmans
Silver city, New Mexico

From: [madeline.bauman](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Friday, September 25, 2026 11:18:48 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe, and I am also a renter, a licensed master of social work, and someone hoping to receive care. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

Psilocybin has changed my life and proven an extremely effective treatment for MDD, anxiety, trauma, and more based on my personal and professional experience.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

I ask the department to consider these solutions:

- a) Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.
- b) Delete paragraph (B)(9) of 7.35.3.11.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Madeline Bauman, PLMSW
Santa Fe, New Mexico

From: [Sherry Yingling](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Friday, September 25, 2026 4:09:47 PM

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To the New Mexico Department of Health: I am a New Mexico resident in Sandia Park, and I am also a clinician. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing. We need to reduce and eliminate barriers to care. I ask the department to make the following changes in the final rule. 1. The property-owner statement, 7.35.3.11(B)(9). Add to paragraph (B)(9) of 7.35.3.11: %20This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents.%20 The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination. 2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D). Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks. The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time %20prescriber%20 gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks. 3. The patient application, 7.35.3.8. Strike the patient application process. It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients. Thank you for considering my comment.
Sherry L. Yingling Sandia Park, New Mexico

Rae (Sherry) Yingling, MA, LPCC
505-420-8088

From: [Alicia Ramos](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Friday, September 25, 2026 6:16:37 PM

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To the New Mexico Department of Health:

My name is Alicia F. Ramos. I am a New Mexico resident living in Roswell, as well as a caregiver, clinician, and someone who hopes to receive this form of care. I am writing to offer public comment on proposed Rule 7.35.3 NMAC ahead of the hearing scheduled for October 2, 2026.

New Mexicans deserve equitable, timely, and compassionate access to care. The final rule should protect patient safety without creating unnecessary barriers that prevent people, especially renters, rural residents, and those with limited financial resources, from receiving treatment.

I respectfully ask the Department to consider the following changes:

1. Property-owner statement — 7.35.3.11(B)(9)

Please delete Paragraph (B)(9) of 7.35.3.11.

The concern that may justify landlord involvement in cannabis use, such as smoking on the property, is not present during a supervised psilocybin session administered by a licensed facilitator. Requiring a property owner's signed acknowledgment offers the owner no meaningful benefit while potentially exposing them to concerns or perceived liability. As a result, many property owners may simply decline to sign.

This requirement would create an inequitable barrier based solely on housing status. New Mexicans who rent their homes should not lose access to care simply because they do not own the property where they live.

2. Certifying clinician — 7.35.3.8 and 7.35.3.9(D)

Please remove the certifying-clinician model. Instead, the rule should focus on the specific contraindications, medical histories, medications, and risk factors that require clinical review.

When an identified risk factor is present, an attestation could be required from a clinician whose scope of practice is appropriate to evaluate that particular concern. The clinician could confirm that the necessary screening was completed and that the potential benefits outweigh the identified risks.

The proposed design appears to extend beyond the intent of the Act and does not fully reflect where the most significant risks may arise. Many of the risks associated with psilocybin-assisted therapy are psychological or involve medical concerns that must be assessed close to—or on—the day of administration, including intoxication or changes in a patient's condition.

A one-time prescriber gateway may not effectively identify or address those risks.

It could also create a separate clinical encounter whose primary purpose is admission into the program rather than independent medical treatment. Insurers may determine that such an encounter lacks medical necessity, increasing the likelihood of claim denials or future clawbacks. This could leave patients and clinicians carrying an unnecessary financial burden.

3. Patient application — 7.35.3.8

Please remove the patient application requirement.

A separate patient application does not appear to have a clear legal or policy justification within a supervised-use program. It would create additional administrative work for the Department, delay access to care, and establish another repository of sensitive patient information that could potentially be accessed without consent, breached, or otherwise misused.

Requiring patients to apply to the state before receiving supervised care may also deepen the stigma already experienced by people seeking mental health and alternative therapeutic services.

New Mexico has an opportunity to create a thoughtful and responsible program that centers safety, dignity, privacy, and equitable access. I respectfully ask the Department to revise the proposed rule so that safeguards are connected to clearly identified risks without creating barriers that unnecessarily restrict care.

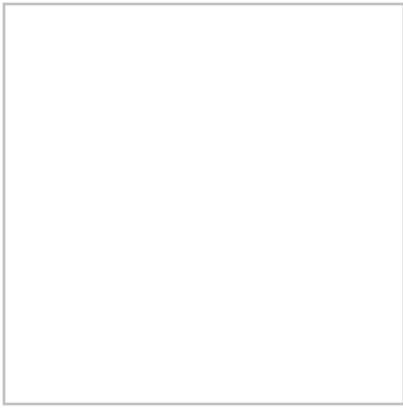
Thank you for considering my comments and for your work in developing this program.

Respectfully,

Alicia F. Ramos
Roswell, New Mexico

Alicia Ramos
MS, EMDR Therapist
Owner, Embodied Sol Therapy & Coaching PLLC

Click here to schedule your appointment today: [Embodied Sol Therapy](#)



"No matter what kind of difficult situation one may find oneself in, some opening, some opportunity to fight one's way out, can always be found. What's most important is to hold fast to hope, to face the future with courage." -Diasaku Ikeda

From: [Maya Albert](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public Comment on Proposed Rule 7.35.3 NMAC - The Synthesis Institute
Date: Friday, September 25, 2026 7:20:04 PM

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Dear Mr. Clark,

Thank you to the Department and to the Medical Psilocybin Advisory Board for the considerable work reflected in the revised proposed rule published August 25, and for the openness to community input that has characterized this process from the start. I am writing as CEO of The Synthesis Institute, a psychedelic practitioner training organization whose Psychedelic Practitioner Certificate Training includes a track for Colorado's regulated program and has trained more than 600 alumni, and I would like to offer comments on two provisions that bear directly on whether New Mexico can build a qualified workforce at the pace the program requires.

1. The in-person didactic requirement

As I read the revised text, the practitioner and facilitator therapy module requires 65 didactic hours, at least one third of which must be delivered in person. Our experience within Colorado's regulated program is that the knowledge-based portion of this training (pharmacology, contraindications, ethics, scope of practice, the legal framework) transfers well to live, synchronous virtual instruction, and that the embodied competencies the Department is rightly concerned with are built in supervised practice with real clients, which the rule already requires at 100 and 120 practicum hours.

We would respectfully ask the Department to consider allowing the didactic module to be delivered fully through live virtual instruction, or alternatively to allow in-person practicum hours to satisfy the in-person component, so that the requirement sits where it does the most good. Given New Mexico's largely rural population and the provider shortage the program is meant to address, we believe an in-person didactic requirement may fall hardest on exactly the clinicians the program most needs to reach, many of whom would need to travel to Albuquerque or Santa Fe, sometimes repeatedly, to complete it.

2. Reciprocity for supervised practicum

The rule provides a reduced practicum through two waiver provisions, which we appreciate as a recognition that supervised experience gained under another state's oversight carries real value. The two provisions appear to conflict: §7.35.3.10(D)(1) requires 40 hours of contact time with two individual sessions and two group sessions for applicants trained through programs in other jurisdictions, while §7.35.3.19(H) requires 40 hours with two individual sessions and one group session for applicants who graduate from an approved program, and an out-of-state applicant could reasonably qualify under either. We would ask the Department to resolve the discrepancy by accepting any practicum completed through an approved or state-regulated program toward the 40 hours, without specifying a number of individual or group sessions, as group formats are one valid modality among several and a fixed session count may create scheduling and cost barriers without a corresponding gain in safety.

We would also ask that this recognition continue beyond December 31, 2027, so that practicum hours completed and documented within another state's regulated program can count toward the New Mexico practicum on an ongoing basis, in the spirit of the waiver authority the Department has already reserved under §7.35.3.10(D)(2) and §7.35.3.19(G) for the program's initial period.

Thank you for the care the Department has brought to this rulemaking, and please let me know if it would be helpful for me or our program team to share further detail on how practicum and didactic training are structured in our Colorado program.

Best,
Maya Albert

Maya Albert
CEO
[The Synthesis Institute](#)

From: [Danielle Leonard](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Supplemental public comment on proposed rule 7.35.3 NMAC – Danielle Leonard, LMHC
Date: Saturday, September 26, 2026 2:11:31 PM

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To the New Mexico Department of Health

Re: Supplemental public comment on proposed rule 7.35.3 NMAC, hearing of October 2, 2026

I am a licensed mental health counselor in Santa Fe, and this supplements my earlier comment. I want to express my support for three parts of the proposed rule and ask the department to keep them in the final rule.

Licensed therapists as practitioners, 7.35.3.9(E) and 7.35.3.18(C). As a counselor, I know how much care it takes to work with people living with treatment-resistant depression, PTSD, and substance use. These are the clients this program is meant to help, and they deserve clinicians who are trained to hold what comes up. Psilocybin sessions can bring trauma and grief to the surface, and much of the real work happens in the weeks of preparation and integration around a session. I'm glad the rule places that work with licensed therapists, who are trained to recognize risk, respond to crises, and plan care over time, and who are accountable to a licensing board and a code of ethics.

I also want to honor the facilitators and elders whose knowledge, care, and courage helped make this program possible. Many of them have deep experience that no training program can replace. I value the role the rule gives facilitators alongside practitioners, and I support the provisions that recognize existing experience, including the option to demonstrate competency through module evaluations and the department's ability to waive requirements where appropriate. I hope the department will continue to look for ways to draw on the wisdom of this community as the program grows.

Practicum standards, 7.35.3.19. No amount of classroom learning fully prepares you to sit with someone in a non-ordinary state. I appreciate that the practicum requires experience with many different patients, in individual and group sessions, and across the qualifying conditions. I especially like that students begin with lower-risk patients, so they can build their skills gradually, and that they present cases to a supervisor before completing the practicum. That is how clinical skill is built in every other part of mental health practice, and I think it makes sense to have it here too.

Post-graduation mentoring, 7.35.3.17(A). Some of my most important learning has come through supervision and consultation, and I have always experienced it as a support rather than a hindrance. Every new clinician meets situations they didn't expect, and having someone experienced to talk them through with makes all the difference, both for the clinician and for the people they serve. I'm glad to see the rule build in at least 10 hours of mentoring after graduation, at no extra cost. Because psilocybin therapy draws on two kinds of expertise, experience with psychedelic states, much of it held by facilitators and elders, and clinical training in mental health, I would encourage the department to ensure that mentoring draws on

both, so new practitioners can learn from each. I also hope the department will look for ways to support ongoing consultation as the program grows.

Together, these provisions mean that New Mexicans in this program will be cared for by clinicians who are well trained, well supported, and accountable. Thank you for the care that has gone into this rule.

Danielle Leonard, LMHC
Santa Fe, New Mexico

From: [Mitchell Tappen](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Medical Psilocybin Program
Date: Saturday, September 26, 2026 3:18:34 PM

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To the New Mexico Department of Health:

I am a New Mexico resident in Albuquerque, and I am also a renter and someone hoping to receive care. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Mitchell Tappen
Albuquerque, New Mexico

Proposed adoption concerning the New Mexico Medical Psilocybin Program:

My name is Paul Walton and I represent Firefighters for Plant Medicine (FFPM). FFPM is a non-profit organization that provides advocacy and education on firefighter and first responder mental health struggles, and on the safe use and best practices for plant medicines and psychedelic assisted healing. I want to thank everyone who made this moment happen in New Mexico history. This is a great opportunity for New Mexico to be leaders in this healing treatment and develop a psilocybin program that is guided by ethics, affordability, and best practices for safe and effective healing that endures time.

As a firefighter for Bernalillo County for almost 19 years, I witnessed and experienced firsthand the physical and emotional toll that such roles can impose on individuals. Our work often involves exposure to traumatic events that can lead to several work-related injuries, such as severe depression and PTSD. First responders have a higher rate of mental health issues and suicide rates. In fact, even with higher rates of work-related cancer, injuries, and fatalities, suicide is still the number one cause of death in first responders.

There is a mental health crisis in our first responders and the front-line medical community, yet they are often overlooked when it comes to mental health treatment and support. These work-related mental injuries often make normal, everyday life a struggle for first responders. These struggles not only affect our first responders, but impacts their families, co-workers and community. Unfortunately, first responders are often the last to seek help due to cultural stigmas surrounding mental health. We are the first to help others but the last to help ourselves. First responders are not getting the treatment they need because of stigmas, affordability, lack of access, and the resistance to treatment.

First responders are not your average mental health patient and need special considerations. Where standard talk therapy and other therapy modalities are often not enough, psilocybin assisted therapy can be the breakthrough treatment that works. There needs to be community and institutional support for this healing process to work and save the lives of our first responders. First responders are in the unique position that they have to go back to work and will be subjected to additional trauma after their treatment. Regulations and policy need to include access for first responders without adverse employment action, with lawful medical support, and with an allowance that first responders may use medical leave for additional integration time after a psilocybin treatment.

While we at Firefighters for Plant Medicine understand the difficulty of developing a program of this nature and the safety guardrails that science and government desire, we do have a couple concerns about the proposed regulations.

In order to have a safe and affective psilocybin program, safety and ethics need to be core principles in therapy treatment. As with any program with financial business gains involved, ethics can sometimes be sidestepped for profit. We hope the state will be diligent in providing an avenue for patients to make reports about safety and ethical concerns, and monitoring programs due to their potential for causing harm when patients are in a vulnerable, non-ordinary state.

New Mexico currently has a substantial shortage of medical personnel, including scheduled drug prescribers. Requiring each participant to get medical clearance via an in-person medical appointment is an undue barrier to treatment that can be safely and effectively avoided. One less restrictive solution is to only require patients who are positive for any of the medical flags (history of cardiac issues, current use of SSRIs, etc.) to be required to see a prescriber for further medical evaluation. All other patients would only need to see a licensed New Mexico provider who can diagnose for the four qualifying conditions of the psilocybin therapy program, screen for any disqualifying medical concerns, and then the NMDOH would review the patient application to check again for medical concerns before approving. I believe this would adequately catch any medical concerns that need to be evaluated and affectively eliminate some of the pressure on an already short-staffed system.

Another concern is that there is no exception to allow practicum students to train and practice with each other. We strongly believe that practicing students should not be working with patients who suffer from severe depression and PTSD. This has serious harm potential for patients, and is not worth the patient risk. Firefighters for Plant Medicine would like to strongly encourage the NMDOH to consider making an exception to the regulations or amend the bill in the upcoming legislative session to allow practicum students to train and learn with each other instead of practicing for the first time with actual qualifying patients. This change in regulation would also address the concern that the number of unique practicum patients currently required would be difficult for any trainee to obtain.

Our hope is that the NMDOH will consider addressing these treatment barriers for New Mexico's first responders and for all New Mexicans who would benefit from medical psilocybin. When our first responders are mentally healthier and happier, their families, co-workers, employers, and communities all benefit.

Warm Regards,



Paul Walton, Executive Director
[Firefighters for Plant Medicine](https://www.firefightersforplantmedicine.org)
www.firefightersforplantmedicine.org



September 28, 2026

Exhibit 8.Y.

New Mexico Department of Health
Medical Psilocybin Program
PO Box 26110
Santa Fe, NM, 87502-6110
jacob.clark@doh.nm.gov

VIA EMAIL

RE: *Comment on Proposed NMAC 7.35.3*

To the New Mexico Department of Health:

The Psychedelic Bar Association (PBA) is a professional association of lawyers and legal professionals committed to the creation of a world where safe, legal, access to psychedelics brings healing, equity and justice for all. The New Mexico Working Group of the Psychedelic Bar Association formed earlier this year in order to offer issue-area expertise during the development of the state regulated program in New Mexico. We are eager to support the success of the New Mexico state regulated access program and are grateful for the opportunity to provide feedback on NMAC 7.35.3.

Our feedback covers the following issue areas:

1. Access issues
2. Safety, liability, and risk management considerations
3. Other recommendations

Access Issues

Provider-to-patient Ratios

Proposed NMAC 7.35.3.20(H)(5) would require "a minimum of one practitioner and one facilitator for individual patient sessions[.]" This rule would require that patients pay for two certified individuals to be present during the entire duration of any individual administration session. We believe that the presence of a second paid individual will

be unnecessary to ensure patient and public safety in a majority of cases, and a rule that requires the hiring of a second individual in all cases would often increase the financial barriers to care without benefit. We submit that a better approach would be to require only a single certified individual. While there may be circumstances in which having a second paid provider is indicated for a particular patient through information learned during screening, we believe that imposing a 2-provider requirement on all patients would create undue cost burdens to a majority of patients without improving client or public safety. By contrast, Oregon's and Colorado's programs require only one facilitator to be present during an individual administration session, and there are no known harms that have come from the lack of a second individual to serve as "back up" out of over 20,000 administration sessions in Oregon and estimated 1,500 in Colorado.

In the context of group administration sessions, draft NMAC 7.35.3.20(H)(5) would require "a minimum of one practitioner for every eight patients and a minimum of one facilitator or qualified student for every two patients." While the ratios required by this rule would allow patients to reduce their costs over individual administration sessions, we are concerned that the amount of administration support required under this draft rule is still out of proportion to the amounts needed to promote patient and public safety.

Establishing mandatory minimum provider-to-patient ratios is problematic because it does not allow the providers to make individualized assessments of the patients and determine how much support is actually needed for particular patients. Tort law, and potentially other DOH regulations, will establish a professional standard of care that does not permit providers to unreasonably defer to these minimum ratios when the idiosyncratic factors of a particular patient group indicate that more administration assistance is needed than required by the regulatory minimums. Adherence to these ratios will not be a safe harbor for civil or professional liability. In other words, *providers will not be able to evade liability when they make or approve of decisions in which the minimum ratios are unreasonably relied upon, regardless of where DOH sets them.* Accordingly, providers of group administrations will have to make safety assessments for patient groups that evaluate the idiosyncrasies of that particular group irrespective of the existence of mandatory minimum ratios.

Additionally, minimum ratios will also create in some providers a cognitive bias known as an "anchoring effect" in which those providers show less diligence or thoroughness in evaluating the relevant safety considerations and instead fully or partially defer to the regulatory minimums. To prevent this, New Mexico should adopt rules that

encourage provider vigilance in ensuring supervision is safe in proportion to the particular risks of the particular patient groups.¹

Mandatory ratios do not give providers flexibility to offer or receive psilocybin services where the costs of safeguards are proportionate to the safety needs of a particular group. The proposed minimums would create paywalls that prevent and deter people from taking psilocybin within the safe and legal container of the Medical Psilocybin program, and work against the objectives of equity and affordability.

If New Mexico wishes to nevertheless adopt minimum ratios, it should consider the examples of Oregon and Colorado. Both states have imposed ratios that consider a patient's dose as a proxy for the minimum amount of support that may be required during group administration.

Oregon has adopted the following ratios²:

Dose (mg of psilocybin analyte)	Minimum Facilitator-to-client Ratio
Less than 5	1 to 25
5 – less than 10	1 to 15
10 – less than 15	1 to 8
15 – less than 25	1 to 6
25 – less than 35	1 to 4
35 – 50	1 to 2

Colorado has adopted a less progressive system, but one that still recognizes that lower-dose sessions will not require as much support. Colorado regulations require 1

¹ We suggest that the list of factors that should be considered by providers when determining the amount of support needed during administration include: 1) the amount of psilocybin being consumed by the patient; 2) the trauma history of the patients; 3) the types of activities the group intends to engage in; 4) the group and its members' prior experience with psilocybin, other psychedelics, or other non-ordinary states of consciousness; 5) the relevant experience and skill of the providers who are administering or supporting the session; 6) the provider familiarity with the clients participating in the session; 7) any physical or behavioral health condition of any patient that increases the likelihood of requiring support during the session; 8) the patients' relevant experience or training in psychedelic peer-support; and 9) any other risk or safety factors that the provider(s) knew or should have known about.

² OAR 333-333-5230.

facilitator to every 8 clients if all clients take 2 mg or less; and 1 facilitator to every 4 clients if any client takes more than 2 mg.³

In short, requiring two providers for individual administration sessions, and establishing minimum provider-to-client ratios for group administration sessions would raise paywalls and make it more difficult for patients to access psilocybin. This exclusionary impact would be most acutely felt on low-income New Mexicans who could otherwise benefit from medical psilocybin but for the unduly high price tag. We encourage DOH to drop the 2-provider requirement for individual sessions, and allow providers to make individualized assessments of group session participants, rather than impose arbitrary minimum ratios.

Certifying Clinician Role

The certifying clinician role design will unreasonably limit patient access. The design requires every patient to see a specifically-permitted DOH provider, who must also hold a New Mexico Controlled Substance Number (and therefore must be a prescribing physician). The encounter must be in person, with few limited exceptions for telehealth. An in-person prescribing physician exam is not an accessible design, especially in a state with a very large rural population and a long-standing provider shortage. Though prescribing physicians should be welcomed into the licensure of the program, to limit access to people who are treated in-person by this small pool of providers is to unnecessarily limit access. We are also concerned that this will create a service gap that will act as an incentive for profit-motivated license holders to dominate the space and charge unreasonable rates (this has been well-documented in the medical cannabis space that similarly limited access to prescribers).

In 2020, the New Mexico state population was 2,120,220, and there were 12,020 DEA-registered prescribers and 351 DEA-registered dispensers. [Current records](#) indicate that there are 29,115 registered members with the Board of Pharmacy in New Mexico, of which less than half have a NM controlled substance number and are registered DEA prescribers. This is a narrow pool of potential persons that could serve as certifying clinicians under the current proposed regulatory requirement of 7.35.3.9(D)(2) requiring certifying clinicians to have a NM controlled substance number.

Requiring a NM controlled substance number effectively filters out many prospective certifiers through a pre-selective regulatory barrier. The regulation narrows the pool of potential certifying clinicians to a small group of risk-tolerant prescribers. Requiring clinicians to have a NM controlled substance number will likely create a small and limited cohort of specialized, independent, and/or advocacy-drive clinicians who must

³ 4 CO Code Regs 755-1 § 617(G).

navigate frictions between the state and federal levels. The frictions between state and federal law creates risk for holders of federal DEA registrations that in many cases are prerequisites for practice in the state among that already limited pool of persons with a NM controlled substance number. This friction may invite more risk-tolerant parties into practice, having an inverse effect upon the statute's intention of risk mitigation. Ultimately, by mandating an NM CS number, the state effectively excludes more accessible low-risk healthcare pathways and funnels the state's medical psilocybin gatekeeping into a highly restricted, self-selective, exclusive subset of risk-tolerant clinicians. Such clinicians may be more prone to acting outside of traditional risk adverse healthcare settings, and their limited number may exacerbate issues of access in an already medical resource scarce environment.

If access along with risk mitigation are motivating factors for the state, then broadening the doorway for certifying clinicians should be a priority. However, requiring a NM controlled substance number prematurely shuts the door for most, effectively having an adverse impact on the state's intended risk mitigation and proposed scale of access. The narrow threshold that a NM controlled substance number requirement creates could actually promote a small number of highly-risk tolerant certifying clinicians operating outside of traditional risk adverse healthcare settings. A small number of highly risk tolerant certifying clinicians operating outside of traditional risk adverse healthcare settings would be considerably less accessible for the New Mexico public in need. This might also create more risk exposure for parties already suffering from complex mental health problems deemed treatable under the statute.

By limiting the number of certifying clinicians through a NM controlled substance number requirement the State's proposed regulation creates scarcity driven incentives by an inverse risk tolerance among proposed certifying providers that contradicts the regulation's intended goal of promoting risk mitigation and access for New Mexico's population in need. Removing a NM controlled substance number will allow for a broader subset of certifying clinicians that would bring into play more traditional risk-adverse healthcare settings that would promote the state's regulatory goal or risk mitigation through wider reaching treatment in more accessible lower-risk healthcare settings.

Patient Application Process

NMAC 7.35.3.8 would require a certifying clinician to submit an application to DOH for prior approval to treat a patient. NMAC 7.35.3.25 would allow DOH to deny or suspend patient eligibility, although there is no reference in the rules to the criteria by which DOH would assess the application.

Without knowing the criteria by which DOH would evaluate patient eligibility, we cannot comment as to the appropriateness of its role in determining patient eligibility on an individual patient basis. However, we generally do not believe that it should be DOH's role or responsibility to make individual eligibility decisions. If DOH does not trust certifying clinicians to make appropriate decisions, DOH should create training or other requirements in order to ensure that those decisions are made correctly. We are concerned that redundancies in determining eligibility will unnecessarily add layers of review, delay care, add arbitrariness into decision-making, and/or increase the costs of administering the program.

"Other Approved Location" Provisions

We applaud the Department for explicitly identifying the needs of patients with disabilities, patients in rural communities, and others in the design of the "other approved locations" provisions. The provision reads, "Such locations may be certified if a qualified patient is unable to be physically transported to a healing center, for other reasons of medical necessity, for purposes of improving patient access in rural and frontier counties, or to enable treatment to occur in a natural environment setting." NMAC 7.35.3.11(B). Because the provision is written as a list of reasons, anything not included would be presumed to be excluded. We recommend either adding a catch all provision (e.g. "or any other reason the Department justifies approval") or to fully anticipate and enumerate reasons for other approved locations that may otherwise be excluded (for example, affordability).

The landlord permission requirement in draft regulations for "other approved locations" should include an explicit exemption for patients seeking care in their own home. The Medical Psilocybin Act makes the medical use of psilocybin legal under state law, and ongoing federal illegality does not justify the landlord permission requirement. Landlords, even those who are supportive of their tenants and of the Program, are unlikely to provide written approval to engage in conduct that remains federally illegal on their premises. Such an attestation would amount to written proof in a legally binding document of aiding and abetting the possession and/or distribution of a Schedule I substance, exposing even the most well-intentioned and supportive landlord to civil and criminal liability. The requirement also creates an opening for exploitation. Landlords who understand that a written approval is a regulatory prerequisite may use that leverage to extract unfair terms or higher rent from tenants lawfully seeking care in their home.

There is also concern that requiring landlord approval for in-home administration would violate patient privacy, HIPAA, and/or state and federal fair housing and civil rights laws, which greatly limit landlords' authority to even inquire into their tenants' disabilities or their medical decision-making. The Medical Psilocybin Act regulations should not

prioritize the property rights of landlords above patient privacy interests and protection against discrimination.

Safety, Liability, and Risk Management Considerations

Clarifying Discussion of Risk Requirements

Regarding patient enrollment and application, the requirements of NMAC 7.35.3.8(A)(7)(c) and (B)(8)(b) that clinicians and patients “discuss the risks of and benefits of medical psilocybin usage” is extremely vague and likely to be interpreted differently by different clinicians. In order to help providers with clarity, we recommend the NM DOH create a non-exhaustive list of particular risks that must be disclosed in order to obtain a patient’s informed consent. One example to look to for guidance is Oregon’s [OAR 333-333-5040](#). Additionally, we recommend the NM DOH standardize the disclosures and their conversations to aid in the uniform administration of medical psilocybin and subsequent data collection regarding program outcomes. NM DOH can look to Oregon for an example of where this has been done well. (see, e.g., Oregon’s [OAR 333-333-5050](#) and its [Client Information Form](#))

Differentiating Between Challenging Experiences and Medical Emergencies in Didactic Training

In 2017, Baylee Ybarra Gatlin died at a festival after psychedelic harm-reduction providers failed to identify that she was experiencing a medical emergency and not merely a “bad trip.” Ultimately, a jury found that the medical screener and the harm-reduction training provider were liable for her death.

While it is unclear whether Ms. Gatlin’s death involved psilocybin, this tragedy highlights the importance of training to identify the rare medical emergency that can arise within the provision of psychedelic care. The required education for certifying clinicians, practitioners, and facilitators should require specific training on differentiating between difficult experiences, or “bad trips,” and medical emergencies.

Other Recommendations

Evaluation of Training Programs

Proposed NMAC 7.35.3.12(A)(19) requires training programs to obtain a “third-party evaluation report that is conducted by a qualified third-party evaluation team.” Third-party evaluators are described in draft NMAC 7.35.3.16 and must be a team of at least three individuals, who, when added together, have expertise in psilocybin therapy, medical and research, and educational curriculum.

Allowing training programs to assemble their own panels of experts to approve of their curriculum is problematic in terms of both the rigor and the integrity of the review. Additionally, it is unclear whether and how DOH rules intersect with NM Higher Education Department regulations. To the extent that compliance with HED regulations is contemplated under DOH rules, DOH should cross-reference HED rules for which compliance is necessary to provide clarity for training programs.

Due Process and Burdens of Proof

When challenging either an adverse determination concerning patient eligibility or a disciplinary action against a certificant, Proposed NMAC 7.35.3.27(L) would put the burden of proof on the appellant to show that the action made or proposed by DOH should be reversed or modified. Such a rule, particularly as applied to certificants, would likely expose DOH to legal challenges and civil liability.

Certificants will have a property interest in their certificate pursuant to Fourteenth Amendment jurisprudence, and that property interest cannot be taken without due process. The burden of proof must be on DOH to remove professional privileges, not on the certificant in order to maintain them. While the State may be able to provide a temporary pause on certificants' activity upon a finding of a public health or safety risk, the restraint must be temporary and the certificant must be offered a post-suspension hearing in which the state bears the burden of proof. See, e.g., *Barry v. Barchi*, 443 U.S. 55 (1979).

Misrepresenting Native American Traditional Use of Psilocybin in New Mexico.

Draft NMAC 7.35.3.18(A)(3) would require training "on the social, cultural and historical aspects of psilocybin use, including traditional use by Native American and other populations in New Mexico[.]" This rule suggests that Native peoples indigenous to NM have traditionally used psilocybin, but we are unaware of any evidence of such use in the state. While we applaud the effort and uplifting the Indigenous origins of psilocybin and other natural psychedelics, it can be harmful and offensive to misrepresent the traditional practices of Native peoples. We recommend changing the rule to require education about other traditional use of other psychedelics by Native peoples who have traditionally inhabited New Mexico, including peyote, and traditional use of psilocybin-containing mushrooms in present-day Mexico.

[Signature page follows.]

////

Respectfully Submitted,



Jonathan M. Dennis

Co-Coordinator of PBA NM Working Group



Brett Phelps

Co-Coordinator of PBA NM Working Group

From: [T.ren](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] 7.35.3 Rulemaking — DOM Participation and Practitioner Eligibility
Date: Monday, September 28, 2026 2:40:30 PM

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Dear Medical Psilocybin Program,

I am a New Mexico-licensed Doctor of Oriental Medicine and am following the Department's current rulemaking for 7.35.3 NMAC.

I understand that the proposed rules are still in development and have not yet been finalized. I would like to participate in the rulemaking process and submit written public comment regarding the role of New Mexico Doctors of Oriental Medicine within the proposed professional eligibility pathways.

In particular, I would like the Department to clarify whether the existing New Mexico DOM license may qualify for the **Practitioner** pathway.

The New Mexico DOM scope of practice includes evaluation, diagnosis, management and treatment of patients, including physical and mental conditions, as well as counseling and education regarding physical, emotional and spiritual balance in lifestyle. The proposed 7.35.3 rule describes the Practitioner credential as a New Mexico professional license permitting the practice of “therapy, counseling, or behavioral services.”

I would therefore like to request that the Department specifically consider and clarify whether the existing scope of a New Mexico Doctor of Oriental Medicine satisfies the Practitioner licensing requirement under the proposed rule.

I would also appreciate information regarding the proper procedure for submitting my written public comment, including any applicable deadline, required committee designation in the subject line, and how my comment will be included in the rulemaking record.

Thank you for your guidance and for providing an opportunity for New Mexico healthcare professionals to participate in the development of these rules.

Respectfully,

Tracey Baca, DOM
Albuquerque, New Mexico

From: [Marcus Best](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public Comment: Medical Psilocybin Program Rules
Date: Tuesday, September 29, 2026 7:23:39 AM

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Dear Mr. Clark,

I am writing to comment on the proposed rules for New Mexico's medical psilocybin program ahead of the October 2 hearing. I support the program and want it to work for the patients and clinicians who will depend on it. Two provisions, as drafted, will limit access without improving safety.

1. Certifying clinician requirement

The rules require an in-person evaluation, with few telehealth exceptions, by a provider holding a New Mexico controlled substance number (an MD or NP). That provider's role is limited to confirming a qualifying diagnosis. They do not advise on medication tapering, on whether a patient is safe to dose, or on anything related to the treatment session itself.

A better model lets the treating practitioner make the diagnostic certification, and requires medical clearance from a prescriber with a controlled substance number only when risk factors are present. The Department can define those factors, for example hypertension, cardiovascular disease, or a history of psychosis. If none are present, a diagnosis should be sufficient. I understand this is consistent with what the legislation intended.

2. DOH patient approval process

After the diagnosis, the patient and certifying clinician must submit paperwork to the Department and wait for approval before treatment can begin. The reviewers have not met the patient and are not making a clinical judgment. The step adds a delay of up to 30 days without adding safety. That delay is most costly for people at end of life and for people with treatment-resistant depression.

Both provisions appear to be carried over from the medical cannabis program. That program involves unsupervised home use. Psilocybin treatment under this program does not. Requirements designed for one setting do not automatically make sense in the other.

I urge the Department to revise both provisions before the rules are finalized.

Thank you for considering my comment.

Sincerely,
Marcus Best
Taos County resident

From: [Gabriel Charalambides](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment: Medical Psilocybin Program rules
Date: Tuesday, September 29, 2026 9:17:15 AM

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Dear Mr. Clark,

I am the founder and CEO of [Odyssey](#). Among other retreats, one of the initiatives we are most proud of is we work with non-profit organizations to provide access to care for veterans and first responders. I am writing to comment on the proposed rules for New Mexico's medical psilocybin program ahead of the October 2 hearing. I support the program and want it to work for the patients and clinicians who will depend on it. Three provisions, as drafted, will limit access without improving safety. Several appear to be carried over from the medical cannabis program, which involves unsupervised home use. Psilocybin treatment under this program does not.

1. Property-owner statement, 7.35.3.11(B)(9)

This paragraph requires a property-owner statement before a patient can receive care at home. I ask the Department to delete paragraph (B)(9) of 7.35.3.11, and I offer two points in support.

a) If the Department wants documentation of a home setting, it can follow Colorado's approach. The patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

b) The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign. Patients who do not own their home would then lose access to care at home before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D)

I ask the Department to remove the certifying clinician design. In its place, the rules should regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, the rules should require an attestation from a clinician whose scope of practice fits that risk, stating that screening was conducted and that the benefits outweigh the risks.

The current design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time prescriber gateway misses them. It also creates a clinical encounter whose sole purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8

I ask the Department to strike the patient application process. It has no legal or policy justification in a supervised-use program. It adds administrative burden for the Department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients. The delay matters most for people at end of life and for people with treatment-resistant depression.

I urge the Department to revise these provisions before the rules are finalized.

Thank you for considering my comment.

Sincerely,
Gabriel Charalambides



[Gabe Charalambides](#)

Founder & CEO

Odyssey | Legal Psilocybin Experiences

☐ odysseypb.com

From: [Janine Sagert](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Tuesday, September 29, 2026 9:41:25 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I am a long time advocate for the responsible use of psychedelics for both clinical and spiritual purposes. I have my PhD in Culture and Mental health from UC-Berkeley which explored the cultural methods of achieving altered, expanded states of consciousness. I made a film, called FROM SHOCK TO AWE, which followed two veteran couples as they sought healing via psychedelics. As well, I am on the board of Limina Foundation,

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Janine Sagert
Santa Fe, New Mexico

From: [Gregory Evans](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Tuesday, September 29, 2026 9:42:28 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe, and I am also a renter. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

It is deeply important to me that the program lands well, reaches people and delivers positive outcomes. Breaking the intended access and equity goals due to unjustified regulation will undo much of the hard work that the department has done to put this together. Below are solutions.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

I ask the department to consider these solutions:

a) Add to paragraph (B)(9) of [7.35.3.11](#): “This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents.”

OR

b) Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time “prescriber” gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Gregory L Evans
Santa Fe, New Mexico

From: [Dr. Scott Shannon](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Psilocybin program.
Date: Tuesday, September 29, 2026 10:50:53 AM

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Dear Mr. Clark,

I am writing regarding the proposed rules for New Mexico's Medical Psilocybin Program. I am a psychiatrist and psychedelic researcher in Colorado, where our clinic has extensive experience with ketamine-assisted therapy and regulated psilocybin services. I have authored many publications in this arena and frequently speak to professional audiences on these exact topics.

I strongly support New Mexico's effort to create a medically responsible psilocybin program. I am concerned, however, that two proposed requirements may add substantial cost and delay without meaningfully improving patient safety.

First, requiring every patient to obtain an in-person certification from a clinician with a New Mexico controlled-substance registration appears unnecessarily restrictive. The Medical Psilocybin Act defines a qualified patient in relation to a clinician's judgment that the person is medically appropriate based on a qualifying diagnosis, and the statute itself does not appear to make prescriptive authority the central clinical safeguard. The data coming out of Oregon's model demonstrates an inordinately low adverse event rate without any restrictions of this kind. From a medical/psychiatric viewpoint the additional certification is simply not needed. This added layer will of course add cost to the system and reduce access.

For psilocybin, the more important safety assessment occurs during preparation and immediately before administration. That assessment needs to consider current medications, cardiovascular status, psychiatric history, changes in health, and other risk factors that may affect whether treatment should proceed. The practitioner who prepares the patient and will be present for treatment is often in the best position to make that assessment.

A more proportionate model would allow an appropriately licensed practitioner to document the qualifying diagnosis and require consultation or medical clearance from a physician or other prescriber when defined risk factors are present—for example, significant cardiovascular disease, uncontrolled hypertension, complex medication interactions, or a history suggesting elevated psychiatric risk. This concentrates medical resources where they actually improve safety rather than requiring an additional evaluation for every patient.

Second, I would reconsider requiring a separate Department of Health approval before treatment can begin. If a qualified clinician has already determined that the patient meets the statutory requirements, an additional administrative review by individuals who have not examined the patient adds little clinical information. A potential delay of several weeks can be particularly consequential for patients with treatment-resistant depression or those receiving end-of-life care. This will needlessly restrict volume and access to care. Our experience in Colorado and those in Oregon highlight the viability of a clinical program without this

restriction and volumes have been much lower than anticipated in both programs, amplifying the concern over access.

A notification or registration model would accomplish the Department's legitimate oversight and data-collection goals without making DOH approval another clinical gate. The Department could retain strong authority to establish standards, audit records, monitor outcomes, investigate adverse events, and enforce compliance.

These distinctions are particularly important because psilocybin under this program is administered in an approved, supervised setting. The risk-management problem is therefore quite different from medical cannabis or another medication that patients take home and use independently.

Good regulation should increase safety while keeping unnecessary barriers as low as possible. In my experience, safety in psychedelic medicine is best achieved through careful preparation, appropriate screening, skilled supervision, clear escalation criteria, and thoughtful follow-up—not by adding duplicative administrative checkpoints.

I encourage the Department to reconsider these two provisions before finalizing the rules.

Thank you for considering these comments.

Sincerely,

Scott Shannon, MD
Psychiatrist and Psychedelic Researcher
Colorado

Scott Shannon, MD
scott.shannon@wholeness.com

From: [Francisca Vega](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Tuesday, September 29, 2026 11:54:58 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Arroyo Seco. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

As a Cancer Survivor I may need to get this easily! 71 years old now. Please.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

I ask the department to consider these solutions:

- a) Add to paragraph (B)(9) of 7.35.3.11: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."
- b) Delete paragraph (B)(9) of 7.35.3.11.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Frances Vega
Arroyo Seco, New Mexico

Sent from my iPhone



September 29, 2026

End-of-Life Considerations and Concerns in the Draft Licensing, Training and Education Rules for New Mexico's Medical Psilocybin Program

Dear Department of Health Staff, Rule-making Team, and Hearing Officer,

End of Life Options New Mexico (EOLONM), a statewide nonprofit organization that provides education, information and support for all end-of-life care options, including medical aid in dying, writes to provide public comment on the draft rules pertaining to Licensure, Training, and Education for New Mexico's Medical Psilocybin Program. Our comments focus on the unique needs of end-of-life patients and sections where the draft rules do not adequately account for these needs. We are grateful for the opportunity to provide feedback on these proposed rules and are committed to the program's success.

NMAC 7.35.3.11 APPLICATION PROCESS FOR HEALING CENTERS AND OTHER APPROVED LOCATIONS

EOLONM is concerned about the landlord permission requirement in the location approval process and requests a clarifying amendment.

The draft provision in question requires:

“Proof of ownership by the qualified patient or attending practitioner or facilitator of any property on which medical psilocybin administration sessions will be conducted, or a signed, written statement from the owner of such property acknowledging that the owner understands that persons will be participating in the medical psilocybin program on the premises, and what those persons are authorized to do within the terms of their certification.”

As written, this requirement applies to any property where an administration session occurs, including a patient's own home. For end-of-life patients and other patients who receive in-home care and who rent rather than own their residence, the provision seems to require them to obtain a signed statement from their landlord acknowledging their participation in the Medical Psilocybin Program and

describing what they are authorized to do under their certification, before they can receive care in their own home.

We understand from MPA Advisory Board/Department discussions that this provision has origins from an analogous requirement within the Medical Cannabis Program. Cannabis is typically smoked or vaporized, and a landlord has a real, practical interest in knowing whether that will occur on their property, given the potential effects on odor, ventilation, and property value. Medical psilocybin administration is a different activity. It occurs during a discrete, clinically supervised session administered by a licensed facilitator, involves no combustion or lingering property effects, and is already governed by the program's own supervision, screening, and safety requirements. The property-owner interest that justifies the cannabis provision simply is not present here in the same way.

What remains, for end-of-life and other patients seeking care in their rented home is the disclosure itself. The requirement effectively conditions a terminally ill or homebound person's access to an in-home medical psilocybin treatment on first disclosing their participation in a state medical program — and the general nature of a private medical condition — to their landlord, a third party with no clinical or regulatory role in their care. That is a forced disclosure of private health information to someone outside the treatment relationship, unsupported by any compelling public policy or private interest that this disclosure serves. It does not appear necessary for patient safety, for facilitator oversight, or for program integrity, all of which are already addressed elsewhere in the draft regulations through facilitator licensure, supervision requirements, and program registration. For a population that is often already navigating precarious housing, serious illness, and limited mobility, asking them to additionally negotiate this disclosure with a landlord is a significant and, we believe, unintended burden.

Residents of long-term care facilities raise a related but separate concern. Similarly, a patient, practitioner, or facilitator would not be the property owner. Facilities already allow physicians, nurses, and hospice staff to provide other forms of care in a resident's room without seeking treatment-by-treatment consent from ownership. Requiring a special permission specific to psilocybin, and not to comparable medical treatments, singles out participants in the program for a disclosure and approval burden that does not appear tied to any actual safety or oversight need.

Given that psilocybin ingestion does not have any property impact, we do not believe the property ownership provision is necessary in the context of medical psilocybin. However, if the Department wishes to retain the provision, we believe there needs to be an exemption to address the above concerns:

"This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

This language would preserve the underlying property-owner protection where it serves a real purpose, while relieving the state's most vulnerable patients of a disclosure obligation that does not appear to advance any safety or oversight goal. We would be glad to discuss this further, to provide any additional information the Department finds useful, or to work with staff on alternative phrasing that achieves the same result.

NMAC 7.35.3.13 REQUIREMENTS AND PROHIBITIONS FOR CERTIFYING CLINICIANS, PRACTITIONERS, AND FACILITATORS

The proposed “certifying clinician” program design introduces a unique access barrier for end-of-life patients. The design would require all program patients to see a DOH-certified provider to confirm their qualifying condition and conduct a health screening, with this exam required in person except in narrow circumstances. Most end-of-life patients already have a well-established medical care team — the physicians best positioned to assess the patient's medical prognosis and the medical appropriateness of psilocybin for that patient — but these physicians are unlikely to also be DOH-certified. Requiring an end-of-life patient to locate an additional, DOH-certified physician simply to confirm the imminence of their own death asks these patients to spend time and energy they do not have.

The safety motives presumed behind the “certifying clinician” design can be accomplished by other means that better account for the access needs of end-of-life and other program patients. Appropriate health and safety screening can be accomplished by permitted practitioners in accordance with the subject matter scope of practice of their underlying healthcare license. Practitioners overseeing patients with risks that exceed their subject matter scope of practice should consult with appropriate experts or refer patients out for additional health screening.

We believe the entry design should be reworked, but if the Department decides to continue with the “certifying clinician” design, we request an exception from this design for end-of-life patients, allowing patients with a prognosis of fewer than 9 months to live to provide physician documentation of the prognosis to gain program entry.

NMAC 7.35.3.8 PATIENT ENROLLMENT APPLICATION PROCESS

The proposed patient application process in the draft rules should be reconsidered. For patients facing terminal or life-limiting diagnoses, every added administrative step in the treatment process is time and energy they may not have. An application-and-approval process introduces delay into care that should be available as quickly as clinically appropriate. It may take some time for the certifying clinician to assemble and submit the required documentation for the application, and then the rules reserve 30 days for the department to review the application. This could add additional months in just administrative time to the care, which for end-of-life patients could mean the difference between receiving relief or dying before it is available. We respectfully request that the Department reconsider

the design.

The application design appears to be a feature borrowed from the Medical Cannabis program structure. The “patient identification card” model in the Cannabis program exists because authorized patients possess, outside of any supervised setting, what would otherwise be an illegal substance. The Lynn and Erin Compassionate Use Act built a patient application process specifically to manage that unsupervised possession risk, but the medical psilocybin program presents no such risk. Because it operates on a model of supervised administration at approved locations only, no patient will ever possess psilocybin outside of a supervised episode. There is no scenario requiring a patient to prove authorization to possess the substance, and therefore no justification for requiring an application or identification card before an end-of-life patient can access care.

For patients who may have weeks or months, not years, the application process will cause further delay between diagnosis and treatment, and for end-of-life patients, this concern is especially acute. We recommend the application process be removed.

We appreciate the opportunity to provide these comments and concerns. People near their end of life have unique challenges that access to medical psilocybin may be helpful with. However, they must be able to obtain this assistance in a manner that acknowledges and is responsive to their physical and emotional frailty. Thanks for your consideration of these recommendations and we look forward to continuing to work with the Department to create and implement this unique and important new program.

Sincerely,



Julia Bergen, Executive Director
End of Life Options New Mexico



Marisa Bartolotta
Compassion & Choices
Policy Counsel

From: [Kate Czark](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Tuesday, September 29, 2026 12:10:11 PM

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To the New Mexico Department of Health:

I am a New Mexico resident in Arroyo Seco, and I am a healthcare worker and also work in hospice and palliative care. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

As a health and hospice care provider I understand how important it is that people have access to these modalities. Creating less friction in the process of someone obtaining the important benefits from medical psychedelics and psilocybin assisted therapy is paramount and beneficial for all parties. Why create more hassle and barriers than is optimal?

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Kate Czark
Arroyo Seco, New Mexico

Sent from my iPhone

From: [Beth Ann Kelly](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Please consider these changes
Date: Tuesday, September 29, 2026 12:53:48 PM

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To the New Mexico Department of Health:

I am a New Mexico resident in Taos, and I am also a caregiver and a hospice care worker. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I work with populations who stand to gain from a psilocybin program and it's really important for the sake of all present and future providers and patients that this rollout avoid obvious pitfalls.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

beth
Taos, New Mexico

B.KELLY
970.729.1700

From: [Anne Vaillant](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Tuesday, September 29, 2026 3:57:11 PM

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To the New Mexico Department of Health:

I am a New Mexico resident in Ranchos de Taos, and I am also a clinician. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

As a psychiatric provider trained in risks and benefits of PAT I want to see this statute rolled out as safely and accessibly as possible

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

Thank you for considering my comment.

Anne Vaillant
Ranchos de Taos, New Mexico

From: [Sara Petrous](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Psilocybin Hearing Oct 2nd - Public Comment
Date: Tuesday, September 29, 2026 7:37:59 PM

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Dear Mr. Clark,

I am writing in regards New Mexico's medical psilocybin program hearing on October 2nd. I am a natural medicine facilitator in the state of Colorado, an Army veteran and a former resident of New Mexico. I am also a person who has healed significantly from the use of Psilocybin therapy. As a veteran, I use the VA for all of my health insurance. My breakthrough moments of healing would not be possible or very hard to achieve, if I were to instead rely on the VA in NM to approve my psilocybin facilitation. As you know, the VA uses federal laws and the new law passed for the psilocybin care would not be possible through the VA or very rare with very many hoops to jump through to be approved. I am not able to afford health care through private insurance and it would not be financially viable for me to seek out a private clinician to approve my work with psilocybin in addition to the fees for the therapy. For someone who is seeking deep care and healing, the price of the session is something alone they must save for and consider. If the criteria for approving therapy is controlled as it is currently outlined in the regulations, very few people will receive help or even bother to go through this process. This program is important for people who want to try this therapy in a safe, supportive and legal environment. Without approval people may instead find medicine that has not been tested, or go to another state when the money could be spent in New Mexico.

The training for a natural medicine facilitator is intensive. It covers ethics, cultural awareness, medication, referring clients, working with clients under a variety of emotions and ailments and so many other important topics. These facilitators are trained and ready to help others. We are unique in that we want to help others grow and heal. We want to sit with them through their hardships and help them recover and contribute more to their communities, families and themselves.

This is true healing work that will impact the state of New Mexico positively one person at a time. Please consider making this step easier for people.

Thank you,
Sara Petrous

From: [Karla Peskuski](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Wednesday, September 30, 2026 8:46:41 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Bosque Farms, and I am also a caregiver. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I am a mother to a Veteran that has received help from a program similar to this program, changed his life after the military. He is now an advocate for other Veterans that can utilize the Medical Psilocybin Program to better their lives.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks. The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

I would also like to note here that the DOH has always advocated for access to health, requiring a one time prescriber or clinician to sign off is a barrier to that access. Many Veterans use the VA for their PCP, these clinicians will not be willing or unable to sign off for admission to this program. To have Veterans seek out a new PCP in our state is a huge barrier. As a health care worker within the UNM system, I

know how long it takes to get a PCP for a pt. Having Veterans wait months if not over a year for this one application step is counterproductive to the program itself.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Karla Peskuski RN BSN
Bosque Farms, New Mexico



September 29, 2026

End-of-Life Considerations and Concerns in the Draft Licensing, Training and Education Rules for New Mexico's Medical Psilocybin Program

Dear Department of Health Staff, Rule-making Team, and Hearing Officer,

End of Life Options New Mexico (EOLONM), a statewide nonprofit organization that provides education, information and support for all end-of-life care options, including medical aid in dying, writes to provide public comment on the draft rules pertaining to Licensure, Training, and Education for New Mexico's Medical Psilocybin Program. Our comments focus on the unique needs of end-of-life patients and sections where the draft rules do not adequately account for these needs. We are grateful for the opportunity to provide feedback on these proposed rules and are committed to the program's success.

NMAC 7.35.3.11 APPLICATION PROCESS FOR HEALING CENTERS AND OTHER APPROVED LOCATIONS

EOLONM is concerned about the landlord permission requirement in the location approval process and requests a clarifying amendment.

The draft provision in question requires:

“Proof of ownership by the qualified patient or attending practitioner or facilitator of any property on which medical psilocybin administration sessions will be conducted, or a signed, written statement from the owner of such property acknowledging that the owner understands that persons will be participating in the medical psilocybin program on the premises, and what those persons are authorized to do within the terms of their certification.”

As written, this requirement applies to any property where an administration session occurs, including a patient's own home. For end-of-life patients and other patients who receive in-home care and who rent rather than own their residence, the provision seems to require them to obtain a signed statement from their landlord acknowledging their participation in the Medical Psilocybin Program and

describing what they are authorized to do under their certification, before they can receive care in their own home.

We understand from MPA Advisory Board/Department discussions that this provision has origins from an analogous requirement within the Medical Cannabis Program. Cannabis is typically smoked or vaporized, and a landlord has a real, practical interest in knowing whether that will occur on their property, given the potential effects on odor, ventilation, and property value. Medical psilocybin administration is a different activity. It occurs during a discrete, clinically supervised session administered by a licensed facilitator, involves no combustion or lingering property effects, and is already governed by the program's own supervision, screening, and safety requirements. The property-owner interest that justifies the cannabis provision simply is not present here in the same way.

What remains, for end-of-life and other patients seeking care in their rented home is the disclosure itself. The requirement effectively conditions a terminally ill or homebound person's access to an in-home medical psilocybin treatment on first disclosing their participation in a state medical program — and the general nature of a private medical condition — to their landlord, a third party with no clinical or regulatory role in their care. That is a forced disclosure of private health information to someone outside the treatment relationship, unsupported by any compelling public policy or private interest that this disclosure serves. It does not appear necessary for patient safety, for facilitator oversight, or for program integrity, all of which are already addressed elsewhere in the draft regulations through facilitator licensure, supervision requirements, and program registration. For a population that is often already navigating precarious housing, serious illness, and limited mobility, asking them to additionally negotiate this disclosure with a landlord is a significant and, we believe, unintended burden.

Residents of long-term care facilities raise a related but separate concern. Similarly, a patient, practitioner, or facilitator would not be the property owner. Facilities already allow physicians, nurses, and hospice staff to provide other forms of care in a resident's room without seeking treatment-by-treatment consent from ownership. Requiring a special permission specific to psilocybin, and not to comparable medical treatments, singles out participants in the program for a disclosure and approval burden that does not appear tied to any actual safety or oversight need.

Given that psilocybin ingestion does not have any property impact, we do not believe the property ownership provision is necessary in the context of medical psilocybin. However, if the Department wishes to retain the provision, we believe there needs to be an exemption to address the above concerns:

"This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

This language would preserve the underlying property-owner protection where it serves a real purpose, while relieving the state's most vulnerable patients of a disclosure obligation that does not appear to advance any safety or oversight goal. We would be glad to discuss this further, to provide any additional information the Department finds useful, or to work with staff on alternative phrasing that achieves the same result.

NMAC 7.35.3.13 REQUIREMENTS AND PROHIBITIONS FOR CERTIFYING CLINICIANS, PRACTITIONERS, AND FACILITATORS

The proposed "certifying clinician" program design introduces a unique access barrier for end-of-life patients. The design would require all program patients to see a DOH-certified provider to confirm their qualifying condition and conduct a health screening, with this exam required in person except in narrow circumstances. Most end-of-life patients already have a well-established medical care team — the physicians best positioned to assess the patient's medical prognosis and the medical appropriateness of psilocybin for that patient — but these physicians are unlikely to also be DOH-certified. Requiring an end-of-life patient to locate an additional, DOH-certified physician simply to confirm the imminence of their own death asks these patients to spend time and energy they do not have.

The safety motives presumed behind the "certifying clinician" design can be accomplished by other means that better account for the access needs of end-of-life and other program patients. Appropriate health and safety screening can be accomplished by permitted practitioners in accordance with the subject matter scope of practice of their underlying healthcare license. Practitioners overseeing patients with risks that exceed their subject matter scope of practice should consult with appropriate experts or refer patients out for additional health screening.

We believe the entry design should be reworked, but if the Department decides to continue with the "certifying clinician" design, we request an exception from this design for end-of-life patients, allowing patients with a prognosis of fewer than 9 months to live to provide physician documentation of the prognosis to gain program entry.

NMAC 7.35.3.8 PATIENT ENROLLMENT APPLICATION PROCESS

The proposed patient application process in the draft rules should be reconsidered. For patients facing terminal or life-limiting diagnoses, every added administrative step in the treatment process is time and energy they may not have. An application-and-approval process introduces delay into care that should be available as quickly as clinically appropriate. It may take some time for the certifying clinician to assemble and submit the required documentation for the application, and then the rules reserve 30 days for the department to review the application. This could add additional months in just administrative time to the care, which for end-of-life patients could mean the difference between receiving relief or dying before it is available. We respectfully request that the Department reconsider

the design.

The application design appears to be a feature borrowed from the Medical Cannabis program structure. The “patient identification card” model in the Cannabis program exists because authorized patients possess, outside of any supervised setting, what would otherwise be an illegal substance. The Lynn and Erin Compassionate Use Act built a patient application process specifically to manage that unsupervised possession risk, but the medical psilocybin program presents no such risk. Because it operates on a model of supervised administration at approved locations only, no patient will ever possess psilocybin outside of a supervised episode. There is no scenario requiring a patient to prove authorization to possess the substance, and therefore no justification for requiring an application or identification card before an end-of-life patient can access care.

For patients who may have weeks or months, not years, the application process will cause further delay between diagnosis and treatment, and for end-of-life patients, this concern is especially acute. We recommend the application process be removed.

We appreciate the opportunity to provide these comments and concerns. People near their end of life have unique challenges that access to medical psilocybin may be helpful with. However, they must be able to obtain this assistance in a manner that acknowledges and is responsive to their physical and emotional frailty. Thanks for your consideration of these recommendations and we look forward to continuing to work with the Department to create and implement this unique and important new program.

Sincerely,



Julia Bergen, Executive Director
End of Life Options New Mexico



Marisa Bartolotta
Compassion & Choices
Policy Counsel

From: [Cheves Fleming](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] DOH Psilocybin Rules
Date: Wednesday, September 30, 2026 6:42:22 PM

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My name is Cheves Fleming. I have a diagnosis for Cluster Headaches, which has been helped by psilocybin. I have been following the formation of this program since the New Mexico Psychedelic Science Society was founded in 2020. Regarding medical psilocybin, accessibility has been a goal since the beginning. Please allow the licensed practitioner to do the diagnostic certification. Furthermore, please allow the licensed practitioner to approve the patient without having to go through the DOH approval process. Accessibility for patients in need can be fast tracked with these rule changes. Thank you for your consideration.

sincerely,
Cheves Fleming

From: [Catherine Warnock](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public Comment on Training Accessibility and Workforce Development, Proposed Rule 7.35.3 NMAC
Date: Wednesday, September 30, 2026 8:20:57 PM

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To the New Mexico Department of Health:

I am writing to express concern about the training and practicum requirements contained in proposed Rule 7.35.3 NMAC and their potential impact on affordability and workforce development.

I strongly support rigorous training for psilocybin practitioners and facilitators. As someone who has provided psilocybin-assisted therapy education and training in New Mexico for several years, I understand firsthand the importance of adequate education, supervised experience, and demonstrated competency.

My concern is not with high standards. It is with whether the proposed structure is the most practical and affordable way to achieve them.

The proposed rules require substantial didactic and simulated-patient education followed by a 100-hour practicum for facilitators and a 120-hour practicum for practitioners. The practicum also requires specific experiences involving individual and group administration, preparation and integration, multiple patients, and different qualifying conditions. NMAC-7.35.3-NewRule NMAC-7.35.3-NewRule

These requirements create costs on **both sides of the training equation**.

Students must be able to afford extensive education and supervised practicum hours. At the same time, educational programs must develop the personnel, patient population, approved locations, supervision, group experiences, and administrative infrastructure necessary to provide those hours.

This creates a significant startup challenge for New Mexico.

Small, locally owned educational programs may simply not have the capital or infrastructure to provide this level of practicum initially. Large universities, healthcare systems, national training organizations, and well-capitalized companies are much better positioned to absorb those costs.

I am concerned that New Mexico could unintentionally create a training system in which **financial capacity, rather than educational quality and demonstrated competency, determines which organizations are able to train our workforce**.

There is also a fundamental workforce-development problem. New Mexico needs trained practitioners and facilitators in order to launch a successful program. Yet educational programs will need patients, approved treatment locations, qualified supervisors, facilitators, and sufficient individual and group administration sessions in order to train those practitioners.

In other words, **the workforce needed to make the program operational depends upon a practicum infrastructure that may not fully exist until the program is already operational.**

This could create a bottleneck precisely when New Mexico needs to rapidly and responsibly develop its workforce.

The cost will ultimately affect patients as well. Training expenses become part of the cost of entering professional practice, and practitioners must eventually recover those expenses through the services they provide. An unnecessarily expensive workforce-development model therefore contributes to an unnecessarily expensive treatment system.

I encourage the Department to reconsider whether competency could be demonstrated through a more flexible practicum model rather than relying primarily on a prescribed number of hours and specific treatment encounters.

I also encourage consideration of:

- A phased practicum requirement during the initial implementation years
- Competency-based pathways that recognize demonstrated skills and prior relevant experience
- Greater flexibility in how required clinical experiences are obtained
- State-supported scholarships or workforce-development funding for New Mexico residents
- Grants or startup assistance for small New Mexico-based educational programs
- Periodic review of the training requirements based on actual workforce capacity, training costs, and patient access after implementation

New Mexico should absolutely establish high standards for those entrusted with this work. But **high standards do not have to mean high financial barriers.**

If we want a diverse workforce that includes community-based clinicians, rural providers, peer-support professionals, and experienced New Mexico practitioners, we must design a training pathway they can realistically enter and educational programs that local organizations can realistically provide.

Otherwise, we risk creating a program that is technically available but dependent upon large institutions and financially inaccessible to many of the very New Mexicans we need to build it.

Thank you for considering these comments.

Catherine Warnock, MA, LPCC, NCC
Las Cruces, New Mexico

Catherine Warnock, MA, LPCC, NCC (she/her)
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575-201-3334 phone/text

575-205-8004 fax

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From: [Amy Wong Hope](#)
To: [Clark, Jacob, DOH](#)
Cc: [Amy Wong Hope](#)
Subject: [EXTERNAL] Public comment on proposed rule 7.35.3 NMAC, hearing of October 2, 2026
Date: Wednesday, September 30, 2026 9:04:54 PM

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Dear Jacob,

I am a New Mexico resident submitting public comment on the proposed rules for the Medical Psilocybin Act. I am a Licensed Clinical Social Worker in New Mexico and Colorado, a Licensed Natural Medicine Clinical Facilitator in Colorado, and the founder of the Psychedelic Studies Certificate Program at Southwestern College School of Counseling in Santa Fe.

My comments are informed by my experience as a mental health clinician and by my direct experience working within Colorado's regulated natural medicine program. I respectfully request that the Department consider the following changes to the proposed rules.

1. Certifying Clinician — 7.35.3.8 and 7.35.3.9(D)

I recommend revising these provisions so that, for qualifying mental health conditions, certification may be provided by a licensed mental health professional whose scope of practice includes diagnosis and assessment of those conditions, rather than requiring certification by a medical prescriber.

There are several reasons for this recommendation:

First, the proposed requirement may create an unnecessary barrier to patient access.

Requiring a patient who already has an established mental health provider to locate a separate medical prescriber willing to conduct a certification evaluation adds another step, additional expense, and potentially significant delays in accessing the program.

Second, medical prescribers may be reluctant to assume this role. Medical prescribers with whom I have spoken have expressed concern about assuming responsibility for certifying a patient following what may be a single diagnostic encounter, particularly when they are not providing the patient's ongoing mental health treatment. Several have indicated that they would be unlikely to participate in the program for this reason. If this experience is widespread, the requirement could substantially limit the number of clinicians willing to provide certifications.

Third, licensed mental health professionals already diagnose and assess mental health conditions within their professional scopes of practice. Licensed mental health clinicians complete graduate-level education, supervised clinical practice, licensure examinations, continuing education, and ongoing professional regulation. Their clinical work routinely includes assessment, diagnosis, differential diagnosis, risk assessment, and treatment of mental health

conditions.

For qualifying psychiatric conditions, these clinicians are therefore well positioned to determine whether a patient meets the diagnostic criteria required by the Medical Psilocybin Act.

It is also important, however, to distinguish **eligibility for the program from clinical readiness and safety for a psilocybin administration session**. A determination that a patient has a qualifying diagnosis should not itself be interpreted as a determination that psilocybin administration is safe or clinically appropriate for that individual at that particular time.

A patient may meet criteria for a qualifying condition while also having co-occurring psychiatric conditions, current symptoms, medications, psychosocial instability, or other factors that require additional assessment before proceeding. Some of these concerns may not be apparent during a single certification visit.

For this reason, I recommend that the rules clearly distinguish between:

1. certification that the patient meets the statutory criteria for participation in the Medical Psilocybin Program; and
2. the subsequent assessment of whether that individual can safely and appropriately participate in a psilocybin administration session.

Without this distinction, patients may understandably interpret certification as a clinical “green light” to proceed. Facilitators may likewise place inappropriate reliance on the certification when making their own safety determinations.

In Colorado, my responsibilities as a Licensed Natural Medicine Clinical Facilitator include assessing whether consultation with other members of a client's health care team is necessary before proceeding. When medical or pharmacological issues fall outside my professional scope, I seek appropriate consultation. In my own practice, I also consult with a PhD-level pharmacologist when medication interactions, contraindications, or other pharmacological concerns require specialized expertise.

I recommend that New Mexico adopt a similarly interdisciplinary approach: when a patient's medical needs fall outside the scope of the evaluating mental health professional or facilitator, consultation with an appropriately qualified medical professional should be required or obtained as clinically indicated.

Finally, I recommend that the Department establish clear screening and safety standards addressing conditions and histories associated with increased risk during psilocybin administration, including bipolar-spectrum conditions, histories of psychosis, and other clinically significant risk factors. Rather than treating every such factor as an automatic exclusion, the rules should clearly identify conditions requiring exclusion, additional evaluation, medical or psychiatric consultation, or heightened clinical consideration.

2. Patient Application — 7.35.3.8

I recommend eliminating the separate patient application process and instead allowing patient enrollment to occur through the certification process.

The certifying clinician could submit the minimum information necessary to establish program eligibility, while maintaining the patient's underlying clinical records in accordance with applicable professional recordkeeping and privacy requirements.

This approach would have several advantages.

It would reduce the administrative burden on patients, particularly patients who are seriously ill, disabled, experiencing significant psychiatric symptoms, or receiving end-of-life care. It would also reduce the administrative infrastructure required of the Department.

More importantly, the Department should consider the principle of **data minimization** when determining what patient information it needs to collect and retain. Psilocybin treatment may involve highly sensitive medical and mental health information. Every additional repository containing identifiable patient information creates an additional privacy and data-security exposure.

I therefore recommend that the Department collect and retain only the minimum patient information necessary to administer the Medical Psilocybin Program, while leaving detailed clinical records with the licensed professionals responsible for maintaining them.

3. Property-Owner Statement — 7.35.3.11(B)(9)

I recommend deleting paragraph (B)(9) of 7.35.3.11 or, alternatively, adding the following exemption:

“This provision shall not apply to end-of-life patients or other patients receiving in-home care, or to residents of long-term care facilities.”

The proposed property-owner requirement creates a particularly significant access issue for patients receiving end-of-life care.

A person with a life-threatening illness may wish to receive psilocybin services in their own home because illness, disability, pain, fatigue, mobility limitations, or the nature of end-of-life care makes travel to another location difficult or inappropriate. A patient who rents their home should not face an additional barrier to receiving otherwise lawful health care solely because they do not own the property in which they live.

We do not ordinarily expect a landlord to make clinical decisions regarding whether a tenant may receive hospice, psychotherapy, physical therapy, nursing, or other lawful health services in the tenant's home. Requiring property-owner authorization for psilocybin services could create a substantially different standard for patients participating in this program.

At minimum, the Department should create an exemption for end-of-life patients, patients

receiving medically necessary in-home care, and residents of long-term care settings.

4. Education Requirements — Touch and Consent

The proposed educational requirements include “Touch and Somatic Awareness.” I recommend that this language explicitly include **touch consent**, for example:

“Touch, Somatic Awareness, and Touch Consent.”

Consent surrounding touch deserves explicit treatment in facilitator education rather than being presumed to fall within general instruction regarding somatic awareness.

Psilocybin can place patients in unusually vulnerable psychological and interpersonal states. Facilitators therefore need specific training regarding obtaining consent for touch, maintaining boundaries, recognizing withdrawal or changes in consent, and understanding that consent given before a session does not eliminate the need to attend to consent during the session.

5. Permissible Touch Between Facilitator and Patient

I also recommend that the Department establish explicit standards defining permissible and prohibited touch between a facilitator and patient during psilocybin services.

Colorado and Oregon have established regulatory boundaries concerning facilitator-client touch. New Mexico should likewise provide facilitators and patients with clear standards rather than leaving the boundaries of permissible touch ambiguous.

The rules should identify the areas of the body where supportive touch may be permitted, establish that such touch requires the patient's prior consent, clarify that consent may be withdrawn at any time, and explicitly prohibit sexualized or otherwise inappropriate touch.

Clear regulatory boundaries protect both patients and facilitators. They are particularly important in psychedelic care because patients may experience increased suggestibility, emotional openness, altered perception, and vulnerability during administration.

For these reasons, I respectfully ask the Department to incorporate explicit **touch-consent education** into facilitator training requirements and to establish clear standards governing permissible touch during psilocybin services.

Conclusion

I support the development of a Medical Psilocybin Program that is clinically responsible, accessible, trauma-informed, and protective of patients. My recommendations are intended to reduce unnecessary barriers to care while strengthening clinical assessment, informed consent, professional accountability, privacy, and patient safety.

Thank you for considering these comments as the Department finalizes the regulations implementing New Mexico's Medical Psilocybin Act.

Respectfully,

Amy Wong Hope, LCSW

Licensed Clinical Social Worker, New Mexico and Colorado

Licensed Natural Medicine Clinical Facilitator, Colorado

Founder, Psychedelic Studies Certificate Program

Southwestern College School of Counseling

Amy Wong Hope, NM LCSW #C-08692

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Website: www.resilientwithin.com (Psychotherapeutic Services) and

www.amywonghope.com (Psychedelic Preparation/Integration Services)

LinkedIn: www.linkedin.com/pub/amy-hope/0/315/368/

From: [cynthusia](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Wednesday, September 30, 2026 9:20:27 PM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe, and I am also a clinician in training. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment. I have personally experienced the healing properties of psilocybin and I believe it will be a great asset to the mental health community if it's patient accessibility is adequate.

Cynthia Gamel
Clinical Counseling Practicum Student

Santa Fe, New Mexico

From: [Chris Riley](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Wednesday, September 30, 2026 9:52:19 PM

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To the New Mexico Department of Health:

I am a New Mexico resident in Rio Rancho. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I am a former firefighter and paramedic. The potential benefits of this support for myself and countless others in dire need of a fresh opportunity are immense. Many of us have been let down by the system, with no viable options available. The research is there, and the individuals who have dedicated their lives and mental well-being to assisting others deserve every chance at recovery in their mental health, just like those recovering from physical injuries sustained in violent encounters.

Please help us create an environment that will FACILITATE this.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Add to paragraph (B)(9) of [7.35.3.11](#): "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that

can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Christopher Riley
Rio Rancho, New Mexico

From: [michael kaplan](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing.
Date: Thursday, October 1, 2026 4:48:37 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe, and I am also a clinician. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

Legal psilocybin-assisted therapy helped me profoundly change my life, my outlook, and my circumstances. Through the experience, I was able to better regulate myself, find the strength to stand up for myself, and begin making meaningful changes in an abusive relationship. It also gave me an immediate sense of hope during a period of severe anxiety and depression, when I had begun considering other, potentially harmful substances as a way of coping.

I ask the Department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time “prescriber” gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comments.

Michael Kaplan, MD

Santa Fe, New Mexico

From: [Trina Zahller](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Thursday, October 1, 2026 5:42:21 AM

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To the New Mexico Department of Health:

Please urgently consider my comments below. I am a New Mexico resident in Albuquerque, and I am also a clinician and someone hoping to deliver PAT care. I trained in OR and NM and am currently a licensed facilitator in CO. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I ask the department to make the following two changes in the final rule. These changes are critical to ensuring that patients will actually have timely and affordable access to care.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment. Tenants are not required to secure landlord permission before consuming or possessing legal opiate medications that have much higher risk for abuse— why would we demand this for psilocybin?

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time “prescriber” gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

Thank you for considering my comment.

Trina Zahller LCSW
Albuquerque, New Mexico

From: [Mary Curry](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Thursday, October 1, 2026 6:31:16 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe, and I am also a clinician. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I specialize in the treatment of traumatic stress, and there is a preponderance of evidence based practice and practice based evidence that full dose treatment and microdose treatment can attenuate suffering and result in a cure for PTSD and other chronic and debilitating psychological conditions.

I plan to attend the hearing. If the opportunity to make a public statement, I will speak to my position that an Integrated Behavioral Health and Primary Care Coordinated Model is the ideal model for the New Mexico Psilocybin Program.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).
 Add to paragraph (B)(9) of [7.35.3.11](#): "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

Instead, I propose an Integrated Mental Health and Substance Abuse and Medical model that is Client/Patient centered.

The entry point of screening and diagnosis is a licensed mental health professional that has

completed a certification to provide psilocybin treatment.

Utilize a screening tool that identifies the psychological and medical conditions that are considered counter indications. If a medical condition (e.g. high blood pressure or other heart condition) the client/patient is responsible for meeting with their physician for clearance to proceed with treatment.

Integrated models have been very successful in New Mexico. I was part of the team that designed the Statewide HIV/AIDS integrated model and the Statewide SBIRT model. These two models utilized Behavioral Health as the point of entry.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Instead, the eligible client/patient process occurs with a certified psilocybin clinician, either directly with their own client/patient, or in collaboration with a referring clinician or medical provider.

Thank you for considering my comment.

Dr. Mary Curry
505-670-8797
Santa Fe, New Mexico

From: [Celeste Yacoboni](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Thursday, October 1, 2026 7:42:44 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I am an ordained minister and licensed massage therapist working with people who hold trauma in their bodies. I have seen the benefits of psilocybin.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

I ask the department to consider these solutions:

- a) Add to paragraph (B)(9) of 7.35.3.11: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."
- b) Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Celeste Yacoboni
Santa Fe, New Mexico

Sent from my iPhone

From: [Jessica Riley](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
Date: Thursday, October 1, 2026 8:13:59 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in Rio Rancho, and I am also a renter, a clinician, and a hospice or palliative care worker. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing. My husband was a paramedic/firefighter for 10 years, and I have seen firsthand the damage that years of repeated trauma can leave behind. First responders see things most people could never imagine, yet alcohol, responsible for roughly 178,000 deaths a year from excessive use, is legal, normalized, and often treated as an acceptable way to cope. It almost took my husband's life. Meanwhile, substances like cannabis and psilocybin have spent decades being stigmatized despite growing research into their therapeutic potential. Psilocybin is not a cure-all, but it deserves serious, responsible study, especially for EMS, fire, law enforcement, and veterans who spend their careers carrying the weight of everyone else's worst days. We should be asking why numbing trauma with alcohol is socially acceptable, while exploring treatments that may actually help people process that trauma is still considered taboo. I ask the department to make the following changes in the final rule. 1. The property-owner statement, 7.35.3.11(B)(9). Add to paragraph (B)(9) of [7.35.3.11](#): "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents." The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination. 2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D). Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks. The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks. 3. The patient application, 7.35.3.8. Strike the patient application process. It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients. Thank you for considering my comment.

Jessica Riley Rio Rancho, New Mexico

From: [Ed Tajchman](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Upcoming hearing
Date: Thursday, October 1, 2026 9:44:16 AM

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To the New Mexico Department of Health:

I am a New Mexico resident in santa fe. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

people need access to holistic medicine in a way that is safe and affordable. If you work with local elders, clinicians, model from other states,... it is possible for New Mexico to help those most in need with holistic medicine. If Texas can pass laws to help those in need with plant medicine, so can New Mexico.

I ask the department to make the following changes in the final rule.

1. The property-owner statement, 7.35.3.11(B)(9).

Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D).

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time “prescriber” gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

Ed Tajchman
santa fe, New Mexico

New Mexico's Magic Mushroom Program Has a Math Problem

The rules may protect patients while pricing the legal market out of existence

By Wendy Robbins

New Mexico is preparing to offer medical psilocybin for treatment-resistant depression, PTSD, substance-use disorders and end-of-life care. This could change lives.

Before we build an expensive new system around a mushroom, let us do some simple math.

One patient would probably consume a macro dose of about 3 to 5 grams during one treatment. **One thousand patients would need only 6.6 to 11 pounds. Ten thousand patients would need only 66 to 110 pounds for the entire year.**

That is roughly the weight of one large dog. One capable commercial grower could produce it.

On today's unregulated market, mushrooms commonly retail for \$5 to \$12 per gram. Those 66 to 110 pounds would be worth approximately **\$150,000 to \$600,000**. Now compare the mushrooms' value with the bureaucratic machinery required to deliver them legally.

The supervision: A full-dose session typically lasts six to eight hours and requires both a practitioner and facilitator. Using illustrative rates of \$200 an hour for the practitioner and \$100 for the facilitator, 10,000 patients would require 20,000 six-to-eight-hour staff shifts—costing \$18 million to \$24 million for supervision alone. That excludes preparation, integration, mushrooms, administrative overhead, insurance and rent.

The proposed training: Practitioners—already licensed healthcare professionals—would need roughly 200 hours of training; facilitators, roughly 180, plus a New Mexico module. No programs are approved yet. At Colorado's rates, training 100 people could collectively cost \$700,000 to \$1.2 million—more than the mushrooms themselves.

The rooms: Ten thousand individual treatments require 10,000 room-days. Even if every room is used 250 days a year, New Mexico would need at least 40 treatment rooms operating continuously. Each needs secure storage, disability access, emergency plans, confidential records, insurance and staff.

One Oregon operator expected to spend \$10,000 on licensing, about \$12,000 on insurance and thousands more on security—before paying rent, renovating or hiring anyone. Apparently, the mushroom needs an entourage and a building code.

The testing: Each separate lot must be tested for potency and contaminants, with some testing repeated after five or six months. New Mexico has not published prices. Oregon's only licensed psilocybin laboratory charges \$600 for a compliance test. Fifty lots would cost \$30,000 before retesting, while a laboratory may need hundreds of thousands of dollars in equipment to serve this tiny market.

Remember: the mushroom is worth \$15 to \$60 per patient.

Regulated experiences may begin around \$1,500, while three- to five-day retreats in Oregon and Colorado commonly cost \$2,500 to \$5,000 or more. Those packages may include preparation, lodging, meals and some follow-up integration.

These are package prices, not practitioner pay. Across 10,000 patients, \$1,500 to \$5,000 each becomes \$15 million to \$50 million in charges.

Oregon is already warning us. Its number of licensed service centers has fallen to about 24. Regulators have proposed doubling annual license fees to \$20,000 for service centers and manufacturers and \$4,000 for facilitators. Apparently, the cure for too few businesses is charging the survivors more.

Colorado has tried to lower costs by allowing micro-healing centers within existing practices. It also allows adults to grow and share mushrooms personally. New Mexico offers neither escape valve.

And then there is microdosing. Microdosing means taking a tiny dose for subtle effects without producing a psychedelic experience. The proposed rules provide no workable pathway.

Imagine 10,000 people taking 0.25 gram three times weekly. That creates 30,000 doses every week and about 860 pounds of annual demand—recurring business that could help support growers and laboratories.

But if every tiny dose requires an authorized session at an approved location, that means **1.56 million supervised appointments annually**. There are not enough practitioners, facilitators, rooms or dollars. A microdose would require a macro-sized bureaucracy.

Microdosing research remains incomplete. That is a reason to study it and create a cautious pathway—not to pretend people are not already using untested products.

New Mexico is not facing a mushroom shortage. It is facing a math problem. Safety rules that make legal treatment unaffordable will send patients back to the unregulated market the rules were supposed to replace.

The Department of Health will hold its rule hearing Friday, October 2, 2026, at 9 a.m. Email written comments to jacob.clark@doh.nm.gov before the hearing closes.

Simply write: I support safe, legal psilocybin treatment. Before adopting these rules, please publish a complete economic analysis, reduce unnecessary costs and create a workable pathway for microdosing. Please show New Mexicans how this program can survive financially.

A program without affordable patients, viable laboratories, trained professionals or open clinics is not a medical program. It is an extremely well-regulated empty room.