

Guest Instructor Application

Approved Instructor Information (Instructor Requesting Guest)

Approved Instructor's Name: _____

Approved Instructor's Number: _____

Phone Number: _____

Email: _____

Guest Instructor Information:

Guest Instructor's Name: _____

Guest Instructor's DOB: _____

Guest Instructor's SSN: _____

❖ Please include a photocopy of the guest instructor's driver's license.

NMAC 10.8.2.24 RESPONSIBILITIES OF APPROVED INSTRUCTORS:

An approved instructor may use guest instructors who are on the department approved instructor list to teach various parts of a firearm training course, but only with written approval of the department.

An approved instructor must file a request for approval to use a guest instructor at least 10 days prior to the date the guest instructor will teach for the first time.

The department will conduct background investigations of guest instructors.

No guest instructor shall teach the approved instructor's entire firearms training course.

An approved instructor shall maintain a file on each guest instructor who teaches any portion of the firearms training course.

The file shall include a list of the dates and portions of the course each guest instructor has taught, and appropriate documents showing the educations, experience, licenses or certifications that qualify the guest instructor to teach the portions of the course he or she has taught.

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY AUTHORIZATION TO OBTAIN HEALTH INFORMATION

This authorization allows the New Mexico Department of Public Safety (DPS) to obtain confidential health information about you. The authorization may be revoked by you. It will remain in effect indefinitely solely for purposes of obtaining information regarding your Concealed Handgun Carry Act application or permit. You are entitled to a copy of the completed authorization. There may be fees charged for any copying associated with this request. If you are a person with a disability and you require this authorization in an alternative format or require a special accommodation to complete this form, you may request assistance from staff at any DPS location.

Applicant Name Printed (First, Middle, Last)

1. I authorize the Department of Public Safety to obtain health information as described below.
2. I understand that any information disclosed by any provider of any kind may include information about behavioral or mental health services, and treatment for alcohol or dmg/substance abuse and information obtained by the New Mexico Department of Public Safety from any other provider specifically related to the statutory purposes set out in the Concealed Handgun Carry Act at Section 29-19-1 to 29-19-13, NMSA 1978.
3. This authorization applies to any health information from any provider or any source relating to the stated purposes.
4. The health information will specifically be related to (a) adjudication of mental incompetence or any commitment to a mental institution; (b) any addiction to alcohol or controlled substances.
5. This health information shall be utilized in order to assess compliance with the purposes of the Concealed Handgun Carry Act.

STATEMENT OF UNDERSTANDING:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the New Mexico Department of Public Safety. I understand that the revocation will not apply to information that has already been obtained pursuant to this authorization. I understand that unless I revoke this authorization as stated above, this authorization will continue in full force and effect. I understand that authorizing the disclosure of this health information is voluntary. I further understand that revoking this authorization may have consequences regarding my application for a concealed handgun carry permit, or my ability to continue carrying a concealed handgun if I have already been issued a concealed handgun carry permit.

Signature of Applicant

Date

Signature of Witness

Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____

NAME (MUST BE PRINTED-LEGIBLY)

(SSN#)

(DOB)

Alias' Name: _____ **SSN:** _____ **DOB:** _____

Name: _____ **SSN:** _____ **DOB:** _____

Department of Public Safety - Concealed Carry Unit

NAME OF AGENCY OR PERSON RECEIVING ARREST RECORD

ADDRESS: 6301 Indian School Rd. NE Suite 310, Albuquerque, NM 87110

AS AN AUTHORIZED AGENT FOR ME FOR THE PURPOSE OF INSPECTING (AND /OR OBTAINING COPIES OF) ANY NEW MEXICO ARREST FINGERPRINT CARD SUPPORTED ARREST RECORD INFORMATION MAINTAINED BY THE DEPARTMENT OF PUBLIC SAFETY, INCLUDING INFORMATION CONCERNING FELONY OR MISDEMEANOR ARRESTS AND INFORMATION OBTAINED FROM RELEVANT FINGERPRINT DATABASES.

TO THE CUSTODIAN OF THE RECORDS IN QUESTION, I HEREBY DIRECT YOU TO RELEASE SUCH INFORMATION TO THE AUTHORIZED AGENT AS DESCRIBED ABOVE.

I HEREBY RELEASE THE CUSTODIAN OR CUSTODIANS OF SUCH RECORDS AND THE DEPARTMENT OF PUBLIC SAFETY, INCLUDING ANY OF THEIR AGENTS, EMPLOYEES, OR REPRESENTATIVES IN ANY CAPACITY, FROM ANY AND ALL CLAIMS OF LIABILITY OR DAMAGE OF WHATEVER KIND OR NATURE, WHICH AT ANY TIME COULD RESULT TO ME, MY HEIRS, ASSIGNS, ASSOCIATES, PERSONAL REPRESENTATIVE OR REPRESENTATIVES OF ANY NATURE BECAUSE OF COMPLIANCE BY SAID CUSTODIAN OR CUSTODIANS WITH THIS "AUTHORIZATION FOR RELEASE OF INFORMATION" AND MY REQUEST CONTAINED HEREIN FOR THIS RELEASE OR BECAUSE OF ANY USE OF THESE RECORDS. THIS RELEASE IS BINDING, NOW AND IN THE FUTURE AND IS VALID FOR A PERIOD OF UP TO 120 DAYS FROM THE DATE SIGNED, ON MY HEIRS, ASSIGNS, ASSOCIATES, PERSONAL REPRESENTATIVE OR REPRESENTATIVES OF ANY NATURE.

APPLICANT SIGNATURE: _____

DATE: _____

SIGNED AND SWORN TO BEFORE ME ON THIS _____ **Day Of** _____ **20** _____

State of _____ **County of** _____

(SEAL)

(SIGNATURE OF NOTARY PUBLIC)

MY COMMISSION EXPIRES: _____

For Department of Public Safety Use Only