New Jersey Department of Health
Public Health and Food Protection Program
P.O. Box 369, Trenton, New Jersey 08625-0369
https://nj.gov/health/ceohs/phfpp/dmd
609-826-4935 | wholesaledrugs@doh.nj.gov

LICENSE/REGISTRATION NO. 500

CURRENT EXPIRATION DATE: _____

RENEWAL APPLICATION FOR REGISTRATION OF A WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS

PURSUANT TO N.J.S.A. 24:6B

Failure to apply for renewal may subject you to penalty as provided by law. Expiration date appears on license. Provide all information requested. If you have discontinued operations, complete last section only. Submit your completed application as an email attachment to: wholesaledrugs@doh.nj.gov

Licensee Name: _____

Trade Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number _____

Email Address _____

☐ **I would like to receive email renewal notices**

Federal Tax ID _____

Mark any changes below. Verification of currently registered locations is available online: NJ.GOV/HEALTH/CEOHS/PHFPP/DMD

- ☐ Change in Trade Name or Mailing Address
- ☐ Change in Officers or Corporate Structure*
- ☐ Change in Manufacturer/Wholesale Distributor operations *
- ☐ Change in Licensed Location(s)*
- ☐ Change in Designated Representative(s)*
- ☐ Change in Controlling Ownership/Tax ID (FORM F-2)*

* Additional documentation is required. For more information, visit our webpage: nj.gov/health/ceohs/phfpp/dmd

ANNUAL RENEWAL FEE (Select One)

$200.00 No more than one (1) location registered to this license

$500.00 Two (2) or more locations registered to this license

$50.00 Gross regulated drug or device business does not exceed 3% of the gross total annual business. (Attach CPA certification of this statement to qualify. Do not combine with other renewal fees.)

VISIT **NJ.GOV/HEALTH/CEOHS/PHFPP/DMD** TO PAY ONLINE WITH A CREDIT CARD OR E-CHECK

Indicate the payment transaction information below. Online payment alone is not sufficient to renew your license. Complete this form (an electronic version of the renewal form is available at the website above) and submit as an attachment via email to **wholesaledrugs@doh.nj.gov** OR make check payable to *NJ Department of Health* and mail to the address at the top of this form. If you submit via email, keep the original paper form for your records. Do not submit in duplicate.

PAYMENT CONFIRMATION # _____ DATE OF PAYMENT _____ AMOUNT _____

ATTESTATIONS

1. In the past four years, has any employee, officer, stockholder, board member associated with the business been indicted or convicted of any federal, state, or local law relating to drug samples, drug manufacturing, wholesale or retail drug distribution, or distribution of a controlled substance? If Yes, attach supporting documentation. ☐ Yes ☐ No
2. In the past year, has the business been subject to disciplinary action by any state? If yes, attach supporting documentation. ☐ Yes ☐ No

CERTIFICATION BY APPLICANT

I hereby certify that the information given in this application is true and complete to the best of my knowledge, information, and belief.

Name and Title of Applicant	Direct Contact Phone Number
Signature of Applicant	Direct Email Address

TO REQUEST DEACTIVATION OF YOUR LICENSE, COMPLETE BELOW

Date Operations Discontinued	Reason for Discontinuation of Operations ☐ Sold ☐ Out of Business ☐ Bankruptcy ☐ Other:
If Sold, Name and Address of Purchaser	