New Jersey Department of Health
Consumer, Environmental and Occupational Health Service
PO Box 369, Trenton, NJ 08625-0369
Phone: 609-826-4935
www.nj.gov/health/foodanddrugsafety

RENEWAL OR DISCONTINUATION APPLICATION TO OPERATE A WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS PURSUANT TO N.J.S.A. 24:6B

FOR THE PERIOD ENDING: January 31, 2020

FOR STATE USE ONLY
Check No.:
Check Date:
Date Received:
Amount:

Any person who engages or continues to engage in the manufacturing or wholesaling of drugs or medical devices without having registered is guilty of a misdemeanor. ALL ITEMS MUST BE FULLY COMPLETED AND THE REQUESTED FEE RECEIVED *BY DECEMBER 31* IN ORDER TO BE RENEWED ON TIME.

Registered as: ☐ Manufacturer ☐ Wholesaler

Registration Number: _____

NEW FEE SCHEDULE

$200.00	If the business has less than 2 locations in state or out of state.
$500.00	If the business has 2 or more locations in state or out of state.
$50.00	For each location in the state if the gross total annual business in drugs or medical devices does not exceed 3% of the gross total annual volume. CPA must complete and sign the Certification section at the bottom of the form.

Make check payable to *"Treasurer, State of NJ."* Payment must be made with company check; no personal checks will be accepted. Or, visit *nj.gov/health/foodanddrugsafety* and follow instructions for online payment. A printed, signed renewal must be mailed.

Federal ID Number: _____

LOCATIONS CURRENTLY CONDUCTING DRUG OR MEDICAL DEVICE BUSINESS
(ATTACH COPY OF CURRENT STATE LICENSE FOR EACH LOCATION.)

_____ _____
_____ _____
_____ _____

IF ADDING OR CHANGING ANY LOCATIONS, YOU MUST COMPLETE BELOW.

(MUST attach copy of license)

Company Name: _____
Street Address: _____
City, State, Zip Code: _____
Responsible Person: _____
Telephone Number: _____ Residential? ☐Yes ☐No
Activity Conducted: ☐Manufacturer ☐Warehouse ☐Repacker ☐Distributor ☐Broker Only ☐Relabeler
☐Reverse Distributor ☐Contract Manufacturer ☐Logistics Provider Company

(MUST attach copy of license)

Company Name: _____
Street Address: _____
City, State, Zip Code: _____
Responsible Person: _____
Telephone Number: _____ Residential? ☐Yes ☐No
Activity Conducted: ☐Manufacturer ☐Warehouse ☐Repacker ☐Distributor ☐Broker Only ☐Relabeler
☐Reverse Distributor ☐Contract Manufacturer ☐Logistics Provider Company

Changes Requested

☐ Change in Trade Name ☐ Change in Corporate Structure ☐ Change in Mailing Address ☐ Change in Ownership

NOTE: For changes that affect the legal entity or ownership, a new registration application must be completed. You are required to notify the New Jersey Department of Health (NJDOH) of any intended/actual change in Trade Name, Corporate Structure, Mailing Address, or Change of Ownership. Change in Ownership requires a new application to be completed.

DISCONTINUANCE OF OPERATIONS INFORMATION
(Include a detailed explanation that all inventory has been accounted for, reclaimed and/or disposed of properly, and the method used.)

Date Operations Discontinued	Reason for Discontinuation of Operations
	☐ Sold ☐ Out of Business ☐ Bankruptcy ☐ Other:

If Sold, Name and Address of Purchaser

ALL ITEMS MUST BE FULLY COMPLETED OR THE RENEWAL APPLICATION WILL NOT BE PROCESSED. RETAIN A COPY FOR YOUR RECORDS. MAIL ORIGINAL COPY WITH YOUR FEE IN THE ENVELOPE PROVIDED.

RENEWAL OR DISCONTINUATION APPLICATION
TO OPERATE A WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS
(Continued)

ALL ITEMS MUST BE FULLY COMPLETED OR THE RENEWAL APPLICATION WILL NOT BE PROCESSED. RETAIN A COPY FOR YOUR RECORDS. MAIL ORIGINAL COPY WITH YOUR FEE IN THE ENVELOPE PROVIDED.

Full Legal Name of Authorized Representative for NJ Commerce *(as defined in N.J.S.A. 24:6B-19)* *(First, Middle, Last):*	**Social Security Number**
Title	**Email Address**
Street Address	**Telephone Number**
City, State, Zip Code	**Fax Number**

ATTESTATIONS

1. Has any employee, officer, stockholder, board member associated with the company 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 control substances? *(If yes, please explain and attach the court decision and adjudication.)* ..... ☐ Yes ☐ No
2. Has the company furnished any false or fraudulent material in any applications made in connection with drug manufacturing or distribution? *(If yes, please explain.)* ..... ☐ Yes ☐ No
3. Have any inspections of your facility resulted in deficient ratings? *(If yes, please explain.)* ..... ☐ Yes ☐ No
4. Has your company met all licensing requirements of your state? Please attach a copy of your most current inspection. *(If no, please explain.)* ..... ☐ Yes ☐ No
5. To the best of your knowledge has the company been denied a license to manufacture and/or distribute prescription drugs in your state, or any other state? *(If yes, please explain.)* ..... ☐ Yes ☐ No

(To be signed by individual Owner, Partner, Corporate President or Shareholder Principal, whichever is applicable.)
I hereby certify that the information given in this statement for Registration is true and complete to the best of my information and belief.

Full Legal Name *(First, Middle, Last)*	**Title**	**Telephone Number**
Signature		**Date**

COMPLETE THIS CERTIFICATION ONLY IF YOU ARE FILING FOR THE $50.00 FEE

CERTIFICATION BY CERTIFIED PUBLIC ACCOUNTANT (CPA)

I hereby certify that the gross total business in drugs or medical devices of Registrant named above does not exceed 3% of the gross total annual volume of business of the registrant.

Signature	Date
Name of Certified Public Accountant (CPA)	License Number
Street Address	City, State, Zip Code

IMPORTANT: YOU MUST ATTACH A COPY OF THE CURRENT STATE LICENSE FOR EACH LOCATION, OR THE RENEWAL APPLICATION WILL NOT BE PROCESSED. THIS RENEWAL APPLICATION MUST BE RECEIVED BY *DECEMBER 31*, IN ORDER FOR THE COMPANY REGISTRATION TO BE RENEWED ON TIME.

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