New Jersey Department of Health
Consumer, Environmental and Occupational Health Service
P. O. Box 369
Trenton, NJ 08625-0369
Phone: 609-826-4935 Fax: 609-826-4990

www.nj.gov/health/foodanddrugsafety

FOOD AND DRUG SAFETY PROGRAM
WHOLESALER DRUG APPLICATION INSTRUCTIONS

Please review the application and return all required fees and complete documentation on the enclosed application. **NOTE: IF THE APPLICATION, ATTACHMENTS, AND ALL REQUIRED INFORMATION IS NOT COMPLETELY SIGNED AND ENCLOSED, YOUR APPLICATION WILL BE RETURNED.**

Misrepresentation of any information on the application is a violation of the laws of the State of New Jersey and may result in the denial of your application or the suspension or revocation of your registration.

1. **APPLICATIONS MUST BE TYPED OR PRINTED LEGIBLY.**

2. **NOTE: OUT-OF-STATE DISTRIBUTORS** – If you are an out-of-state distributor, please attach a copy of the license/permit/registration of your company's resident state when you submit this application.

3. **AS PART OF THE APPLICATION, THE FOLLOWING ATTACHMENTS ARE REQUIRED.** Send photocopies only; do not send originals:
    - Federal ID Tax Certificate(s)
    - If a corporation, Certificate of Incorporation
    - If a Limited Liability Corporation (LLC), Certificate of Limited Liability Corporation
    - Federal DEA License, if handling Controlled Dangerous Substances
    - Resident State Controlled Dangerous Substance License, if handling Controlled Dangerous Substances
    - Resident State License, if your company is located outside of New Jersey.

For any questions, please contact the Food and Drug Safety Program at (609) 826-4935. Thank you.

New Jersey Department of Health
Consumer, Environmental and Occupational Health Service
PO Box 369
Trenton, NJ 08625-0369
Phone: 609-826-4935 Fax: 609-826-4990
www.nj.gov/health/foodanddrugsafety

FOR STATE USE ONLY

☐Check ☐MO #_____
Date Received _____
Amount _____
Certificate No. _____
Registration No. _____
Date Issued _____
Check all that apply:
☐Mfg ☐Whrse ☐Repacker
☐Dist ☐Broker Only ☐Relabeler
☐SCBA Only
☐Other: _____

REGISTRATION OF DRUG OR MEDICAL DEVICE MANUFACTURING OR WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS
(N.J.S.A. 24:6B)

FEE: $200 - Single location in the State or out of State
$500 - 2 or more locations in State or out of State
$50 - for each location in the State if the gross total annual business in drugs does not exceed 3% of the gross total annual volume. (CPA Certification is required.)

A check or money order, payable to "New Jersey Department of Health" must accompany this Registration. Registration must be renewed prior to February 1 of each calendar year.
NOTE: If more space is required, attach supplemental sheets identifying each item corresponding to the number on this Registration form.

SECTION I - IDENTIFICATION

1. Name of Parent Company	2. Telephone Number ( )
3. Mailing Address (Street)	4. Fax Number ( )
5. City, State, Zip Code	6. Federal ID Number *(MUST attach copy of certificate)*
7. Email Address	8. Web Address
9. Trade Name (Doing Business As)	10. Telephone Number ( )
11. Mailing Address (Street)	12. Fax Number ( )
13. City, State, Zip Code	14. Federal ID Number *(MUST attach copy of certificate)*
15. Email Address	16. Web Address

17. List all locations in which your company manufactures, stores and/or distributes for the Drug or Medical Device Manufacturing or Wholesale Drug or Medical Device Business Conducted in ANY State:

Location A:
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
☐Other (specify): _____

Location B:
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
☐Other (specify): _____

REGISTRATION OF DRUG OR MEDICAL DEVICE MANUFACTURING
OR WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS (Continued)

SECTION I - IDENTIFICATION

Location C:

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
☐Other (specify): _____

Location D:

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
☐Other (specify): _____

Location E:

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
☐Other (specify): _____

Location F:

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
☐Other (specify): _____

18. Have you ever made application for registration in New Jersey? ☐Yes ☐No

A. If Yes, year of previous application: _____

19. Does your company **IMPORT**? ☐Yes ☐No

A. If Yes, provide information on company(ies):

Name of Company: _____

Address of Company: _____

_____

Country: _____ FDA Reg. No.: _____

Name of Company: _____

Address of Company: _____

_____

Country: _____ FDA Reg. No.: _____

Name of Company: _____

Address of Company: _____

_____

Country: _____ FDA Reg. No.: _____

REGISTRATION OF DRUG OR MEDICAL DEVICE MANUFACTURING
OR WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS (Continued)

SECTION I - IDENTIFICATION

20. Does your company **EXPORT**? ☐Yes ☐No

A. If Yes, provide information on company(ies):

Name of Company: _____

Address of Company: _____

_____

Country: _____ FDA Reg. No.: _____

Name of Company: _____

Address of Company: _____

_____

Country: _____ FDA Reg. No.: _____

Name of Company: _____

Address of Company: _____

_____

Country: _____ FDA Reg. No.: _____

21. List All of the states with which your company possesses current Registration. Provide License Number and Expiration Date for each.

	Lic. No.	Exp.Date		Lic. No.	Exp.Date		Lic. No.	Exp.Date		Lic. No.	Exp.Date
AK			ID			NC			SC		
AL			IL			ND			SD		
AR			IN			NE			TN		
AZ			KS			NH			TX		
CA			KY			NJ			UT		
CO			LA			NM			VA		
CT			MA			NV			VI		
DC			MD			NY			VT		
DE			ME			OH			WA		
FL			MI			OK			WI		
GA			MN			OR			WV		
GU			MO			PA			WY		
HI			MS			PR					
IA			MT			RI					

22. If the registrant's business is not conducted from a location within the State, you are required to provide the name of the company appointed as New Jersey Registered Agent: _____

NJ Registered Agent: _____

Street Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Locations from which NJ customers are serviced:

Address: _____

Address: _____

SECTION II - BUSINESS STRUCTURE

1. Provide the Names and Residential Addresses of Owners, Partners, Officers and Agents:

A. SOLE OWNERSHIP

Name: ______________________________

Residence Street Address: ______________________________

City, State, Zip Code: ______________________________

Residence Telephone Number: ______________________________

Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________

Place of Birth – City, State: ______________________________ Country: __________

Percent Owned: __________

Signature: ______________________________

B. PARTNERSHIP

Name of Partner: ______________________________

Residence Street Address: ______________________________

City, State, Zip Code: ______________________________

Residence Telephone Number: ______________________________

Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________

Place of Birth – City, State: ______________________________ Country: __________

Percent Owned: __________

Signature: ______________________________

Name of Partner: ______________________________

Residence Street Address: ______________________________

City, State, Zip Code: ______________________________

Residence Telephone Number: ______________________________

Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________

Place of Birth – City, State: ______________________________ Country: __________

Percent Owned: __________

Signature: ______________________________

Name of Partner: ______________________________

Residence Street Address: ______________________________

City, State, Zip Code: ______________________________

Residence Telephone Number: ______________________________

Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________

Place of Birth – City, State: ______________________________ Country: __________

Percent Owned: __________

Signature: ______________________________

Name of Partner: ______________________________

Residence Street Address: ______________________________

City, State, Zip Code: ______________________________

Residence Telephone Number: ______________________________

Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________

Place of Birth – City, State: ______________________________ Country: __________

Percent Owned: __________

Signature: ______________________________

SECTION II - BUSINESS STRUCTURE

B. PARTNERSHIP, Continued

Name of Partner: ______________________
Residence Street Address: ______________________
City, State, Zip Code: ______________________
Residence Telephone Number: ______________________
Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________
Place of Birth – City, State: ______________________ Country: __________
Percent Owned: __________
Signature: ______________________

Name of Partner: ______________________
Residence Street Address: ______________________
City, State, Zip Code: ______________________
Residence Telephone Number: ______________________
Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________
Place of Birth – City, State: ______________________ Country: __________
Percent Owned: __________
Signature: ______________________

Name of Partner: ______________________
Residence Street Address: ______________________
City, State, Zip Code: ______________________
Residence Telephone Number: ______________________
Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________
Place of Birth – City, State: ______________________ Country: __________
Percent Owned: __________
Signature: ______________________

C. INCORPORATION * *(Attach copy of Certificate of Incorporation)*

*In case of a corporation with more than one Division, list Division Officers responsible for NJ operation.

Date of Incorporation: __________ State: __________

President: ______________________
Residence Street Address: ______________________
City, State, Zip Code: ______________________
Residence Telephone Number: ______________________
Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________
Place of Birth – City, State: ______________________ Country: __________
Percent Owned: __________
Signature: ______________________

Vice-President: ______________________
Residence Street Address: ______________________
City, State, Zip Code: ______________________
Residence Telephone Number: ______________________
Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________
Place of Birth – City, State: ______________________ Country: __________
Percent Owned: __________
Signature:

SECTION II - BUSINESS STRUCTURE

C. INCORPORATION (Continued)

Secretary: _____

Residence Street Address: _____

City, State, Zip Code: _____

Residence Telephone Number: _____

Social Security Number *(Last 4 Digits Only)*: _____ Date of Birth: _____

Place of Birth – City, State: _____ Country: _____

Percent Owned: _____

Signature:

Treasurer: _____

Residence Street Address: _____

City, State, Zip Code: _____

Residence Telephone Number: _____

Social Security Number *(Last 4 Digits Only)*: _____ Date of Birth: _____

Place of Birth – City, State: _____ Country: _____

Percent Owned: _____

Signature:

_____

Other Officer/Director: _____

Residence Street Address: _____

City, State, Zip Code: _____

Residence Telephone Number: _____

Social Security Number *(Last 4 Digits Only)*: _____ Date of Birth: _____

Place of Birth – City, State: _____ Country: _____

Percent Owned: _____

Signature:

_____

Other Officer/Director: _____

Residence Street Address: _____

City, State, Zip Code: _____

Residence Telephone Number: _____

Social Security Number *(Last 4 Digits Only)*: _____ Date of Birth: _____

Place of Birth – City, State: _____ Country: _____

Percent Owned: _____

Signature:

SECTION II - BUSINESS STRUCTURE

D. OTHER *[Designate the type of business structure, if other than private ownership, partnership or corporation, for example: Limited Liability Corporation (LLC). Attach a copy of Certificate of Limited Liability Corporation.]*

Type of Structure: ______________________

Name of Partner: ______________________
Title: ______________________
Residence Street Address: ______________________
City, State, Zip Code: ______________________
Residence Telephone Number: ______________________
Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________
Place of Birth – City, State: __________ Country: __________
Percent Owned: __________
Signature: ______________________

Name of Partner: ______________________
Title: ______________________
Residence Street Address: ______________________
City, State, Zip Code: ______________________
Residence Telephone Number: ______________________
Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________
Place of Birth – City, State: __________ Country: __________
Percent Owned: __________
Signature: ______________________

Name of Partner: ______________________
Title: ______________________
Residence Street Address: ______________________
City, State, Zip Code: ______________________
Residence Telephone Number: ______________________
Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________
Place of Birth – City, State: __________ Country: __________
Percent Owned: __________
Signature: ______________________

Name of Partner: ______________________
Title: ______________________
Residence Street Address: ______________________
City, State, Zip Code: ______________________
Residence Telephone Number: ______________________
Social Security Number *(Last 4 Digits Only)*: __________ Date of Birth: __________
Place of Birth – City, State: __________ Country: __________
Percent Owned: __________
Signature: ______________________

REGISTRATION OF DRUG OR MEDICAL DEVICE MANUFACTURING
OR WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS (Continued)

SECTION III - RECEIPT OF ORDERS SERVED

1. List the names and addresses of officers, registered agent, or legal counsel, upon whom orders of the Commissioner may be served:

A. Name: _____

Residence Street Address: _____

City, State, Zip Code: _____

Residence Telephone Number: _____

B. Name: _____

Residence Street Address: _____

City, State, Zip Code: _____

Residence Telephone Number: _____

SECTION IV - DESCRIPTION OF BUSINESS/PRODUCTS

1. Are you engaged in inter-state commerce? ☐Yes ☐No

2. Are the following products and/or activities conducted at any of your locations involving prescription drugs and/or prescription veterinary drugs? ☐Yes ☐No

3. **Indicate which of the following products and/or activities are conducted at each of the locations you listed on Page 1, Section 1, Question 17, by checking the appropriate box:**

	Location A	Location B	Location C	Location D	Location E	Location F
A. Prescription drugs which fall under the Federal Prescription Drug Marketing Act of 1987, 21 U.S., C. 351, 353, 371 and 374 and C.F.R. 205	☐	☐	☐	☐	☐	☐
B. Non-prescription, non-legend or over-the-counter (OTC) drugs	☐	☐	☐	☐	☐	☐
C. Medical devices	☐	☐	☐	☐	☐	☐
D. OTC veterinary drugs	☐	☐	☐	☐	☐	☐
E. Prescription veterinary drugs	☐	☐	☐	☐	☐	☐
F. Manufacturing, compounding, processing, wholesaling, jobbing, or distribution of controlled dangerous substances as defined by law	☐	☐	☐	☐	☐	☐
G. Transfilling of scuba oxygen tanks	☐	☐	☐	☐	☐	☐
H. Medical gases	☐	☐	☐	☐	☐	☐
I. Repacking	☐	☐	☐	☐	☐	☐
J. Relabeling	☐	☐	☐	☐	☐	☐
K. Reverse distribution	☐	☐	☐	☐	☐	☐
L. Contract manufacturing	☐	☐	☐	☐	☐	☐
M. Controlled dangerous substances	☐	☐	☐	☐	☐	☐
N. Medical gases	☐	☐	☐	☐	☐	☐

4. DEA Registration Number: _____ ***(Attach a COPY of the Certificate(s) to this application.)***

5. CDS State Registration No.: _____

SECTION IV - DESCRIPTION OF BUSINESS/PRODUCTS

6. List the drugs or medical device products manufactured or distributed for sale or wholesaled. **The list must be a complete attestation of all drugs and products handled and distributed. The list MUST itemize exact product names, NDC numbers and exact dosages**. You may enclose a CD, catalog or printed drug list of your products for this registration.

SECTION V – CORPORATE OFFICERS EMPLOYMENT

1. Please provide the Corporate Officers' (all principals in the Business Structure) past and present experience in the manufacturing or distribution of drugs or device manufacturing or distribution. Provide name, location and phone number of previous employers and time of employment. **As part of this application, attach a copy of the resume for each employee and complete this section.**

A. Name of Employee: _____

Do you hold any other position with any other company? ☐Yes ☐No

Name of Company: _____

Position Held: _____

City, State, Zip Code: _____

Telephone No.: _____ Contact Person: _____

Period of Employment: Begin Date: _____ End Date: _____

Type of Operation: ☐Manufacturer ☐Primary Dist. ☐Secondary Dist. ☐Broker ☐Repacker ☐Retailer

B. Name of Employee: _____

Do you hold any other position with any other company? ☐Yes ☐No

Name of Company: _____

Position Held: _____

City, State, Zip Code: _____

Telephone No.: _____ Contact Person: _____

Period of Employment: Begin Date: _____ End Date: _____

Type of Operation: ☐Manufacturer ☐Primary Dist. ☐Secondary Dist. ☐Broker ☐Repacker ☐Retailer

C. Name of Employee: _____

Do you hold any other position with any other company? ☐Yes ☐No

Name of Company: _____

Position Held: _____

City, State, Zip Code: _____

Telephone No.: _____ Contact Person: _____

Period of Employment: Begin Date: _____ End Date: _____

Type of Operation: ☐Manufacturer ☐Primary Dist. ☐Secondary Dist. ☐Broker ☐Repacker ☐Retailer

SECTION V – CORPORATE OFFICERS EMPLOYMENT

D. Name of Employee: _____

Do you hold any other position with any other company? ☐Yes ☐No

Name of Company: _____

Position Held: _____

City, State, Zip Code: _____

Telephone No.: _____ Contact Person: _____

Period of Employment: Begin Date: _____ End Date: _____

Type of Operation: ☐Manufacturer ☐Primary Dist. ☐Secondary Dist. ☐Broker ☐Repacker ☐Retailer

E. Name of Employee: _____

Do you hold any other position with any other company? ☐Yes ☐No

Name of Company: _____

Position Held: _____

City, State, Zip Code: _____

Telephone No.: _____ Contact Person: _____

Period of Employment: Begin Date: _____ End Date: _____

Type of Operation: ☐Manufacturer ☐Primary Dist. ☐Secondary Dist. ☐Broker ☐Repacker ☐Retailer

F. Name of Employee: _____

Do you hold any other position with any other company? ☐Yes ☐No

Name of Company: _____

Position Held: _____

City, State, Zip Code: _____

Telephone No.: _____ Contact Person: _____

Period of Employment: Begin Date: _____ End Date: _____

Type of Operation: ☐Manufacturer ☐Primary Dist. ☐Secondary Dist. ☐Broker ☐Repacker ☐Retailer

G. Name of Employee: _____

Do you hold any other position with any other company? ☐Yes ☐No

Name of Company: _____

Position Held: _____

City, State, Zip Code: _____

Telephone No.: _____ Contact Person: _____

Period of Employment: Begin Date: _____ End Date: _____

Type of Operation: ☐Manufacturer ☐Primary Dist. ☐Secondary Dist. ☐Broker ☐Repacker ☐Retailer

H. Name of Employee: _____

Do you hold any other position with any other company? ☐Yes ☐No

Name of Company: _____

Position Held: _____

City, State, Zip Code: _____

Telephone No.: _____ Contact Person: _____

Period of Employment: Begin Date: _____ End Date: _____

Type of Operation: ☐Manufacturer ☐Primary Dist. ☐Secondary Dist. ☐Broker ☐Repacker ☐Retailer

REGISTRATION OF DRUG OR MEDICAL DEVICE MANUFACTURING
OR WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS (Continued)

SECTION VI – CONVICTIONS / SUSPENSIONS

1. Has the company or any principals or its owners or partners been convicted under any Federal or local laws relating to drug samples, wholesale or retail drug distribution or medical devices?

   ☐Yes ☐No

   a. If Yes, explain: _____

2. Is the registrant's Federal or State registration for the manufacture or distribution of prescription drugs or controlled substances currently or previously been suspended or revoked?

   Federal Registration: ☐Yes ☐No State Registration: ☐Yes ☐No

   a. If Yes, explain: _____

SECTION VII – CERTIFICATION

To be signed by Individual Owner, Partner, Corporate President or Responsible Principal, whichever is applicable.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of New Jersey regulating the operation of a wholesale drug or medical device business may be grounds for the revocation/suspension of this registration.

I have read all questions, answers and statements and know the contents thereof. I hereby certify under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the New Jersey Department of Health, it's agents, servants and employees to conduct any investigation(s) of my business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

I am aware that if any of the foregoing statements are willingly false, I am subject to punishment.

Name	Title
Signature	Date
Name	Title
Signature	Date

SECTION VIII - NOTARY PUBLIC

State of _____

County of _____

Subscribed and sworn to before me this

_____ day of _____,20_____.

Notary Public of the State of _____.

MY COMMISSION EXPIRES: _____. By_____

SECTION IX - CERTIFICATION BY CERTIFIED PUBLIC ACCOUNTANT OR PUBLIC ACCOUNTANT

I hereby certify that the gross total business in drugs of the above-named registrant does not exceed 3% of the gross total annual volume of the registrant's business.

Name of CPA or Public Accountant		Certificate Number
Address		
Signature	Telephone Number ( )	Date