

**RENEWAL APPLICATION FOR LICENSE TO OPERATE  
A WHOLESALE FOOD-COSMETIC ESTABLISHMENT  
PURSUANT TO N.J.S.A. 24:15-1**

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: [wholesalefood@doh.nj.gov](mailto:wholesalefood@doh.nj.gov)

LICENSED LOCATION ADDRESS: \_\_\_\_\_

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 \_\_\_\_\_

**IF INFORMATION ON FILE HAS CHANGED,  
MAKE NECESSARY CORRECTIONS BELOW**

- Change in Trade Name
- Change in Corporate Structure
- Change in Mailing Address
- Change in Licensed Location \*
- Change in Ownership/Tax ID \*

\* If the owner/tax ID has changed or the operations have moved to a different location, the existing license number will be deactivated. An initial application form F-29 is required for a new license. Find the initial application on our website: [nj.gov/health/ceohs/phfpp/wfc](https://nj.gov/health/ceohs/phfpp/wfc)

INDICATE ANNUAL GROSS WHOLESALE BUSINESS based on your last fiscal year.

		RENEWAL FEE
<input type="checkbox"/>	1. Less than \$100,000.00	\$150.00
<input type="checkbox"/>	2. Excess of \$100,000.00, but not in excess of \$500,000.00	\$500.00
<input type="checkbox"/>	3. Excess of \$500,000.00	\$1000.00

**VISIT [NJ.GOV/HEALTH/CEOHS/PHFPP/WFC](https://nj.gov/health/ceohs/phfpp/wfc) TO PAY ONLINE WITH A CHECK OR CREDIT CARD**

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 [wholesalefood@doh.nj.gov](mailto:wholesalefood@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 \_\_\_\_\_

**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. Write "NA" if a field is not applicable.**

Date Operation Discontinued	Reason for Discontinuance
Date Sold	Name and Address of Purchaser
Signature of Former Operator	Address of Former Operator

**SUBMIT COMPLETED APPLICATION AS AN ATTACHMENT BY EMAIL TO: [WHOLESALEFOOD@DOH.NJ.GOV](mailto:WHOLESALEFOOD@DOH.NJ.GOV)**