

**New Jersey Department of Health and Senior Services
Consumer and Environmental Health Services
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
WHOLESALE 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.

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FOR STATE USE ONLY	
<input type="checkbox"/> Check	<input type="checkbox"/> MO # _____
Date Received	_____
Amount	_____
Certificate No.	_____
Registration No.	_____
Date Issued	_____
Check all that apply:	
<input type="checkbox"/> Mfg	<input type="checkbox"/> Whrse <input type="checkbox"/> Repacker
<input type="checkbox"/> Dist	<input type="checkbox"/> Broker Only <input type="checkbox"/> Relabeler
<input type="checkbox"/> SCBA Only	
<input type="checkbox"/> 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 and Senior Services" 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 <i>(MUST attach copy of certificate)</i>	
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 <i>(MUST attach copy of certificate)</i>	
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 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: _____

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

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: _____

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

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: _____

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

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Non-prescription, non-legend or over-the-counter (OTC) drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Medical devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. OTC veterinary drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Prescription veterinary drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Manufacturing, compounding, processing, wholesaling, jobbing, or distribution of controlled dangerous substances as defined by law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Transfilling of scuba oxygen tanks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Medical gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Repacking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Relabeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Reverse distribution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Contract manufacturing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Controlled dangerous substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Medical gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

5. CDS State Registration No.: _____

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

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

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

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 State Department of Health and Senior Services, 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
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Signature	Date
-----------	------

Name	Title
------	-------

Signature	Date
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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
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Address

Signature	Telephone Number ()	Date
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