

New Jersey Department of Health
Consumer, Environmental and Occupational Health Service
P. O. Box 369
Trenton, NJ 08625-0369
Phone: 609-826-4935
Email: dmd@doh.nj.gov
Website: www.nj.gov/health/ceohs/phfpp/dmd

**PUBLIC HEALTH AND FOOD PROTECTION PROGRAM
WHOLESALE DRUG APPLICATION INSTRUCTIONS**

Please review the application and return all required fees and complete documentation on the enclosed application.

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.
 - Name, direct contact information, and last seven (7) years of work history for the Designated Representative of each location submitted for registration.

For any questions, please contact the Public Health and Food Protection Program via email: dmd@doh.nj.gov. Thank you.

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**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.)

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: _____

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: _____

**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	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐

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 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