

LICENSE/REGISTRATION NO.

CURRENT EXPIRATION DATE:

**RENEWAL APPLICATION FOR REGISTRATION OF A
 WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS**
 PURSUANT TO N.J.S.A. 24:6B

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: dmd@doh.nj.gov

Mark any changes below. Verification of currently registered locations is available online:
nj.gov/health/ceohs/phfpp/dmd

Licensee Name:

Trade Name:

Mailing Address:

City: State: Zip Code:

- Change in Trade Name or Mailing Address
- Change in Officers or Corporate Structure*
- Change in Manufacturer/Wholesale Distributor operations *
- Change in Licensed Location(s)*
- Change in Designated Representative(s)*
- Change in Controlling Ownership/Tax ID (FORM F-2)*

* Additional documentation is required. For more information, visit our webpage: nj.gov/health/ceohs/phfpp/dmd

Licensee Phone Number

Licensee Email Address

Federal Tax ID

ANNUAL RENEWAL FEE (Select One)	
\$200.00	No more than one (1) location registered to this license
\$500.00	Two (2) or more locations registered to this license
\$50.00	Gross regulated drug or device business does not exceed 3% of the gross total annual business. (Attach CPA certification of this statement to qualify. Do not combine with other renewal fees.)
<p>VISIT nj.gov/health/ceohs/phfpp/dmd TO PAY ONLINE WITH A CREDIT CARD OR E-CHECK</p> <p>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 dmd@doh.nj.gov OR make check payable to <i>NJ Department of Health</i> 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.</p>	
PAYMENT CONFIRMATION #	DATE OF PAYMENT
AMOUNT	
ATTESTATIONS	
1. In the past four years, has any employee, officer, stockholder, board member associated with the business 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 a controlled substance? If Yes, attach supporting documentation.	Yes
	No
2. In the past year, has the business been subject to disciplinary action by any state? If yes, attach supporting documentation.	Yes
	No
REQUIRED ATTACHMENTS	
1. For each out-of-state registered location, a copy of the resident state wholesale distributor or manufacturer license. 2. Product list current as of the date of application submission.	
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	
Date Operations Discontinued	Reason for Discontinuation of Operations
	Sold Out of Business Bankruptcy Other:
If Sold, Name and Address of Purchaser	