New Jersey Office of the Attorney General
Division of Consumer Affairs
Board of Pharmacy
124 Halsey Street, 6th Floor, PO Box 45013,
Newark, NJ 07101
(973) 504-6450

Instructions to submit a New Jersey In-State Pharmacy Application

Prior to submitting, via email, a new application for an In-State Pharmacy registration, ensure that all required information is completed on the application, with appropriate signatures and notarization. Supporting documents should be notarized where required, and attached with your application, as a single PDF file, to your email submission. Also, in that email, *please include the name, phone number and email address of the person who will act as the point-of-contact with the Board during the application process*. Once your application has been reviewed, your contact will receive a follow-up email from the Board containing next steps and an invoice so that you may pay the application fee on-line. To ensure proper processing of your application email, the subject line should be formatted as follows:

"<Insert Name of Pharmacy> - In-State Pharmacy Application Documentation"

- **New Pharmacy Applications** – Please **email** (as one single PDF) your completed application to the Board office at njbopoffice@dca.njoag.gov.

- For subsequent changes of Name, Ownership, and Location Applications – Please **upload** (as one single PDF) your completed application to the pharmacy's *MyLicense* account.

Please complete the below application in its entirety

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Pharmacy Permit Application

Please print clearly.

Pursuant to N.J.S.A. 45:14-40, I or we, _____, hereby make application for a permit to conduct the pharmacy referred to below until June 30th next, and certify to the correctness of the following information:

(Please check the appropriate box below. List the present owner or address where applicable.)

- ☐ Transfer of ownership from _____
- ☐ Change of location from _____
- ☐ Remodeling
- ☐ New pharmacy

1. (a) Name under which pharmacy is to be operated: _____
   (b) Is the above name registered in the office of the county clerk? ☐ Yes ☐ No
   (c) Telephone number: _____
   (include area code)

   (d) _____
   Street address of pharmacy — Nearest cross street

   _____
   City — State — ZIP code — County

2. Type of permit: ☐ Retail ☐ Institutional
   Type of practice(s) in which the pharmacy is to engage: (Check all that apply.)

☐ Standard retail pharmacy	☐ Retail pharmacy department	☐ Long-Term Care pharmacy
☐ Mail order pharmacy	☐ Nuclear pharmacy	☐ Sterile admixture retail
☐ Hospital pharmacy	☐ Hospital satellite pharmacy	☐ Specialty pharmacy
☐ Other, please indicate: _____		

3. If application is **not** being made for a corporation, list below the names and addresses of individuals, partners, trustees, receivers, executors or other persons in whom ownership will be vested.

Full name of owner	Home address	Percentage of ownership	R.Ph. License Number

4. If application is being made for a corporation, complete the information requested below:

   (a) _____
   Name and address of registered agent of the corporation

   (b) Date of incorporation: _____
   (c) Is the corporation's stock: ☐ publicly traded; or ☐ nonpublicly traded?

Names and addresses of all officers and owners of 10 percent or more of stock

(d) President _____
Name of officer | Home address | Percentage of stock | R.P. Certificate Number

(e) Vice Pres. _____
Name of officer | Home address | Percentage of stock | R.P. Certificate Number

(f) Secretary _____
Name of officer | Home address | Percentage of stock | R.P. Certificate Number

(g) Treasurer _____
Name of officer | Home address | Percentage of stock | R.P. Certificate Number

(h) Others _____
Name of officer | Home address | Percentage of stock | R.P. Certificate Number

_____
Name of officer | Home address | Percentage of stock | R.P. Certificate Number

5. Fill in the information requested below for all of the Registered Pharmacists to be employed at this pharmacy. List the Pharmacist-in-Charge in line (a) below:

(a) (in charge) _____
Full name of Registered Pharmacist | Hours employed per week | Original Certificate Number

(b) _____
Full name of Registered Pharmacist | Hours employed per week | Original Certificate Number

(c) _____
Full name of Registered Pharmacist | Hours employed per week | Original Certificate Number

(d) _____
Full name of Registered Pharmacist | Hours employed per week | Original Certificate Number

(e) _____
Full name of Registered Pharmacist | Hours employed per week | Original Certificate Number

6. Hours: This pharmacy will be open a total of _____ hours per week.
Open weekdays from _____ a.m. to _____ p.m. Open Sundays from _____ a.m. to _____ p.m.
Open Saturdays from _____ a.m. to _____ p.m.
Hours to be closed for meals or other exceptions (other than major U.S. holidays) _____

7. Pharmacist-in-Charge _____
Name | Address | Home telephone number (include area code)

8. Are there any pending indictments of any nature or any alleged violations of the laws governing the practice of pharmacy, dispensing narcotics, alcohol, hypnotic or other regulated drugs against any of the individuals listed in items three, four, and five of this application, or have any of them been convicted of any crime within the past 10 years? (Attach additional sheets if needed.) ☐ Yes ☐ No
If "Yes," give details. _____
_____

9. Paste a copy of your prescription label and a copy of your poison label in the spaces indicated below:

(If labels are not available, they can be supplied separately as soon as they are available.)

10. Please provide the name of supportive personnel and all other unregistered employees connected with prescription and drug departments. If none, write "None." (Attach an additional list if more space is needed.)

_____
Full name | Home address | Hours employed per week

_____
Full name | Home address | Hours employed per week

_____

11. How many pharmacies do you operate in New Jersey? _____ (Attach list of any additional pharmacies.)

_____ _____
Pharmacy name Address

_____ _____
Pharmacy name Address

_____ _____
Pharmacy name Address

12. (a) Date upon which a change of ownership, moving to a new location or opening or remodeling of a pharmacy is anticipated: _____.

(b) Date premises will be ready for inspection: (If the ready date for inspection changes for any reason, the Board of Pharmacy must be notified, in writing, in a timely manner.)_____ .

The information requested below, regarding the specifications, equipment and facilities of the prescription area, must be filled in completely.

13. Floor dimensions of the pharmacy. Please give the length and width including the portion occupied by the prescription area, but not including stock and storage rooms. Length: _____ Width: _____

14. Floor dimensions of the prescription department including space occupied by fixtures. Length: _____ Width: _____

15. Width of prescription counter, free of overhanging shelves: _____ Total length of counters: _____

16. We now possess or have ordered the equipment as outlined in the Board of Pharmacy Regulations. ☐ Yes ☐ No

(Note to purchasers of existing pharmacies: you are to note below the equipment as outlined in the Board of Pharmacy Regulations which is not now available in your pharmacy. At the time of your inspection, you must show a purchase order for the missing equipment.)

17. The outline on page four of this application is a true representation of the dimensions of the pharmacy setting forth, in detail, the prescription department fixtures.

Affidavit

18. Affidavit A, below, must be completed by the owner, or a partner, as listed in item three on page one or by a principal officer as listed in item three or four on page one if the pharmacy or drug store is owned by a corporation. If the person executing Affidavit A is not also the Registered Pharmacist-in-Charge of the pharmacy or drug store, then the Registered Pharmacist-in-Charge must complete Affidavit B.

Each Affidavit must be sworn to before a Notary Public or other authorized officer.

I do solemnly swear and affirm that the answers and statements made in this form are true and correct to the best of my knowledge and belief, and that the prescription area of this pharmacy has all of the equipment and facilities with the exceptions noted on this application, which will be obtained immediately, and meets all of the specifications enumerated in the "Prescription Area Regulations" a copy of which I have seen. In the event of loss or breakage of any item on the equipment list, it will be replaced promptly. I also agree to display the permit and understand that the permit is not transferable and agree to return it to the Board upon request. If I should move, sell or discontinue this pharmacy or if it is damaged by fire or by any other occurrence at any time, I agree to notify the Board of Pharmacy immediately. **Affidavit "A" must be executed on every application.**

Affidavit "A"

(see item 18 above)

_____
Name of pharmacy (if a corporation, give exact legal title)

_____
Signature (circle title below)

owner, partner, trustee, receiver, lessee, executor, president, secretary

Subscribed and sworn to before me this _____
day of _____ A.D. _____
Notary's signature _____
My commission expires _____

AFFIX SEAL HERE

Affidavit "B"

(see item 18 above)

_____
Signature of Registered Pharmacist-in-Charge

Subscribed and sworn to before me this _____
day of _____ A.D. _____
Notary's signature _____
My commission expires _____

AFFIX SEAL HERE

CORPORATION SEAL (IF ANY)

To Notary Public: Please make sure that the person taking the oath has read all of item 18.

Draw an outline of the floor plan of the pharmacy, including the prescription area and stockrooms, on this page. If the length of the room is less than 72 feet, consider each square as measuring two feet on each side. If the length of the store exceeds 72 feet, consider each square equivalent to four feet on each side. Indicate the space allotted to each department according to scale. Use ink when making the sketch, if possible. Please use a ruler in making the drawing.

Outline prescription area fixtures in detail with dimensions.

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Affidavit "C"

All questions must be answered and forwarded to the Board of Pharmacy together with the Application for Renewal of Registration and Permit to Operate a Pharmacy. No renewal permit will be issued without a signed and dated Affidavit ''C," which will be affixed to and become a part of the Application for Renewal of Registration and Permit to Operate a Pharmacy. Answer all of the questions completely.

Please check "Yes" or ''No."

1. Does any physician(s), or other person(s) authorized to write prescriptions in the State of New Jersey, possess any financial interest, direct or indirect, in the pharmacy? ☐ Yes ☐ No

2. Does any physician(s), or other person(s) authorized to write prescriptions in the State of New Jersey, possess any lease-hold interest, direct or indirect, in the pharmacy? ☐ Yes ☐ No

3. Does any physician(s), or other person(s) authorized to write prescriptions in the State of New Jersey, own or possess any interest, direct or indirect, in the building in which the pharmacy is located? ☐ Yes ☐ No

4. Are there any outstanding loans, to or from, physician(s) or other person(s) authorized to write prescriptions in the State of New Jersey? ☐ Yes ☐ No

5. If the answer to any of the above is "Yes," kindly answer the following questions. Please type or print clearly.

   a. Is the physician(s) or other person(s) practicing in the trading area of this pharmacy? ☐ Yes ☐ No

   b. Name and address of the physician(s) or other person(s):

   _____

   _____

   _____

   c. Extent and description of the financial interest. Please provide a full explanation:

   _____

   _____

   _____

   _____

I certify that the statements made by me on Affidavit "C"are true. I am aware that if any of the statements made by me are willfully false, I am subject to punishment.

_____
Name of pharmacy (If a corporation, give the exact title.)

_____ _____
Date Signature of owner or officer

Title (check one): ☐ Owner ☐ Partner ☐ President ☐ Secretary ☐ Treasurer

Affidavit Regarding Internet and/or Mail Order Pharmacy Activity

This matter was opened to the New Jersey State Board of Pharmacy by application of _____ _____ **to operate a pharmacy in the State of New Jersey.** The applicant, who may engage in Internet and/or mail order pharmacy activity under a retail permit granted pursuant to the signature on this Affidavit, has agreed to the following conditions prior to commencing either or both of the above-listed services:

1. _____ is hereby granted a retail permit to operate a pharmacy in the State of New Jersey, subject to the following ongoing conditions set forth in paragraphs 2 through 4 below.

2. _____. ("applicant") shall obtain the National Association of State Boards of Pharmacy Verified Internet Pharmacy Practice Site Certification prior to engaging in Internet or online dispensing.

3. The applicant shall make all reasonable efforts to ensure that all prescriptions received via the Internet, or by mail, are valid, to wit, there exists a prescriber-patient relationship and that a reasonable and prudent pharmacist would believe that the patient has been physically examined by the prescriber or the collaborating physician. The applicant shall not accept any prescription for dispensing where he knows or should have known that the prescription has been written pursuant to an online diagnosis or survey by a prescriber.

4. The applicant shall not act as a facilitator of prescriptions being transferred by the Internet or by mail to any pharmacy in or outside of the United States that he knows or should have known dispenses in violation of the conditions set forth in Paragraph 3 of this Affidavit. This paragraph shall not preclude the routine transfer of the prescription as requested by the patient as authorized by State and federal law.

Affidavit of Applicant

I, _____, agree being duly sworn, depose and say under penalty of false statement, I am the party described as above; that the information given in this Affidavit and submitted materials contain no willful misrepresentations and that the information is true and complete. I understand that should an investigation at any time disclose otherwise, I may face legal sanctions. I understand that in signing this Affidavit, I am consenting to any reasonable inquiry that may be necessary to verify the information I have provided in this document.

_____ _____
Applicant's Full Signature Date

_____ _____
Notary's Full Signature Date

Notary's Commission Expires: _____