Date of report: _____

Date of incident: _____

NJPB INCIDENT REPORT

Please print clearly.

Send To:
State of New Jersey
Office of Drug Control-NJPB Unit
P.O. Box 45045
Newark, New Jersey 07101
Telephone: (973) 424-8159 or (973) 792-4240
Fax: (973) 504-6326
E-Mail: collinsc@dca.lps.state.nj.us

From: (Identify Person Reporting Incident)
Name and Title: _____
(Prescriber/Healthcare Facility/Printer/Pharmacist/Law Enforcement Agency/Other)
Address:_____
_____
Telephone number (include area code): _____
Fax number (include area code): _____

Include a copy of the RX (if available) along with a written narrative of the specific circumstances and a copy of the police report (if reported).

Section I. - Personal Information

_____
(Name of Prescriber and Professional Degree or Name of Healthcare Facility appearing on the involved NJPB form.)

_____
(Professional License Number or Healthcare Facility Provider Number appearing on the involved NJPB form.)

_____
(Street address)

_____
(City, State, County and ZIPcode)

_____
Telephone number (include area code)

Section II. - The Incident that occurred involves

(Check Applicable Incident and as appropriate complete Sections "III," "IV" and "V" of this form.)

- ☐ Misplaced (Lost)
- ☐ Stolen
- ☐ Damaged
- ☐ Lost in Delivery
- ☐ Forged
- ☐ Altered
- ☐ Counterfeit
- ☐ Other (Describe below):

_____
_____
_____

Section III. - Description

The number of missing NJPB's is estimated to be: _____ Batch number: _____
Serial number: _____
The name of the printer from whom the NJPB's were purchased: _____

The Incident involving the missing NJPB's:

1. ☐ Has not been reported to any law enforcement agency, governmental agency or professional licensing board.

2. ☐ Has been reported to the following law enforcement agency, governmental agency or professional licensing board:

(1) Name: _____
Address:_____
Telephone number (include area code): _____
Person: _____

(2) Name: _____
Address:_____
Telephone number (include area code): _____
Person: _____

(3) Name: _____
Address:_____
Telephone number (include area code): _____
Person: _____

(4) Name: _____
Address:_____
Telephone number (include area code): _____
Person: _____

Section IV. - Details

A. List the perpetrator(s) involved in the Incident and provide each individual's name, address, telephone number and date of birth.

(1) Name: _____
Address: _____
_____
Telephone number (include area code): _____
Date of birth: _____

(2) Name: _____
Address: _____
_____
Telephone number (include area code): _____
Date of birth: _____

B. Was the person involved in the Incident arrested? ☐ Yes ☐ No
If "Yes," enter:

1. Name of law enforcement agency: _____
2. Address: _____
3. Telephone number (include area code): _____
4. Arresting officer or contact at agency: _____

C. Check whether the medication involved in the Incident was a:

1. ☐ C.D.S. (Enter name of controlled substance): _____
2. ☐ P.L.D. (Enter name of legend drug): _____

D. Was an attempt made to bill a Third Party Prescription Program for the medication involved in the Incident? ☐ Yes ☐ No
If "Yes," enter the following information:

1. The name of the program administrator: _____
2. The telephone number (include area code) (if available): _____
3. The patient's I.D. number: _____
4. The third party group number: _____
5. The policy number: _____
6. Was the third party administrator notified of the Incident? ☐ Yes ☐ No
   If "Yes," enter:
   The name of the person to whom the Incident was reported: _____

Section V. - Additional Information

A. Enter the name, address and telephone number of the pharmacy or pharmacies where the missing blanks were reported as having been presented to be filled:

(1) Name: _____
Address: _____
_____
Telephone number (include area code): _____

(2) Name: _____
Address: _____
_____
Telephone number (include area code): _____

B. Please provide a copy of the RX (if available) along with a written narrative of the specific circumstances with this report.

Signature and title of the person preparing this Incident Report: _____