Controlled Dangerous Substance Registration
Initial Application for Registration for Dispenser Pharmacy
Instruction sheet

i. **New Jersey Controlled Dangerous Substance (CDS) Pharmacy Registration Requirements:**

Enclosed is a CDS application, which you are required to submit pursuant to N.J.S.A. 24:21-1 et seq. Registration is required for every person who or firm that prescribes, manufactures, distributes, conducts research or analysis, or dispenses controlled dangerous substances within this State.

A New Jersey CDS registration is issued to an actual location including out-of-state, where controlled dangerous substances will be stored, prescribed, dispensed, etc. The address of record cannot be a post office box.

A New Jersey Board of Pharmacy (BOP) permit is the prerequisite to the CDS registration. If you do not already have a permit, please complete the Application for an Out-of-State Pharmacy Registration found at https://www.njconsumeraffairs.gov/phar/Pages/applications.aspx.

ii. **Federal Drug Enforcement Administration (DEA) Registration Requirement:**

A New Jersey CDS registration is the prerequisite to the federal DEA registration. Pursuant to N.J.A.C. 13:45H-1.2(m), CDS registrants must provide the Drug Control Unit with its federal DEA registration number within 60 days of registration. The address associated with your DEA registration must correspond with your CDS registration address of record. Your home state DEA registration is acceptable so long as the address associated corresponds with your CDS registration address of record. **Please submit a copy of your current federal DEA registration to CDS@dca.njoag.gov.**

For federal DEA registration questions please contact the DEA Registration Service Center at 1-800-882-9539, DEA.Registration.Help@usdoj.gov, and/or visit https://www.deadiversion.usdoj.gov.

iii. **Out-of-state Pharmacies:**

In addition to the above mentioned requirements, when applying for a CDS registration you must use the same address of record filed with the BOP. You may review your pharmacy address of record at https://newjersey.mylicense.com/eGov/Login.aspx. For questions or additional assistance please contact the BOP at NJBOPOffice@dca.njoag.gov.

iv. **Automated Medication System (AMS)**

Prior to submitting a CDS AMS application you must first contact the BOP at NJBOPOffice@dca.njoag.gov. You may only submit a CDS AMS application upon notice of approval from the BOP.

When applying for a CDS AMS registration you must use the address at which the machine will be located.

Please note that any Automated Medication System installed in a Long Term Care facility located in New Jersey must be under the control of a New Jersey based pharmacy. For additional questions, please contact the BOP at NJBOPOffice@dca.njoag.gov.

v. **Application Completion:**

All items must be completed. Please type or print clearly.

In addition to the above mentioned requirements, pharmacies applying for a CDS registration are required to use their common trading name (e.g. David Pharmacy), not a business or corporate name.

If additional space is required for your response to any question on the application, please submit a separate sheet of paper identifying the section(s) to which you are responding.

vi. **Application Fee:**

The CDS application fee is $40.00. If your application is submitted by email, an invoice which will include instructions for submitting payment will be emailed to you. If your application is submitted by mail (see next section), please include a $40.00 check or money order payable to "State of New Jersey."

vii. **Application Submission:**

Complete the enclosed application and attestation and submit by email to CDS@dca.njoag.gov or mail along with a check or money order to Drug Control Unit, P.O. Box 45045, Newark, NJ 07101.

viii. **Additional Information:**

For current application processing time and additional information please visit https://www.njconsumeraffairs.gov/dcu/Pages/Phases-and-Timelines.aspx#.

Upon issuance, your CDS registration will be mailed to the mailing address on file with the Board of Pharmacy.

If we can be of further assistance, please email CDS@dca.njoag.gov or call (973) 504-6351.

New Jersey Office of the Attorney General
Drug Control Unit
P.O. Box 45045
Newark, NJ 07101

Please type or print clearly.

Initial Application for Registration for Dispenser – Pharmacy

New Jersey Controlled Dangerous Substances Act
N.J.S.A. 24:21-1 et seq.

Section A: All of the items in this section must be completed.

1. Provide the applicant's name and the place of business to be registered (do not use solely a P.O. box). The address of record must be your pharmacy/facility location. Note that your address of record will not remain confidential, and is subject to public disclosure by the Division.

Pharmacy permit trade name

Last name | First name | MI
C.D.S. – Responsible Individual

Department | Room number

Street address

City | State | ZIP code

Home telephone number (include area code) | Business telephone number (include area code)

Note: Please note that the above-registered address is subject to inspection pursuant to N.J.S.A. 24:21-31 & 32.

2. Registration requested as:
☐ Dispenser ($40) ☐ Automated Medication System ($40)
See preceding instruction sheet for application fee submission instructions.

3. Registration requested in the following Schedule(s):
Schedule ☐ II ☐ III ☐ IV ☐ V

4. (a) Has any restriction been imposed which would affect your privilege to hold a controlled dangerous substances (C.D.S.) registration for Schedule II, III, IV or V substances in New Jersey, any other state, the District of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

(b) Have you been arrested, indicted or convicted of a crime in connection with controlled substances under federal law or the laws of New Jersey, any other state, the District of Columbia or any other jurisdiction?* ☐ Yes ☐ No

(c) Have you ever surrendered a controlled drug registration or had a controlled drug registration revoked, suspended or denied in New Jersey, any other state, the District of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

(d) If the applicant is a corporation, association, or partnership: has any officer, partner, stockholder holding 10% or more of the outstanding shares or employee who has access to controlled dangerous substances been convicted of a crime in connection with controlled substances under federal law or the laws of New Jersey, any other state, the District of Columbia or any other jurisdiction?* ☐ Yes ☐ No

(e) If the applicant is a corporation, association, or partnership: has any officer, partner, stockholder holding 10% or more of the outstanding shares or employee who has access to controlled dangerous substances surrendered a controlled drug registration, had a controlled drug registration suspended, revoked, or denied, or owned or worked for an entity which has surrendered or had revoked, suspended, or denied a controlled drug registration under federal law or the laws of New Jersey, any other state, the District of Columbia or any other jurisdiction?* ☐ Yes ☐ No

*** If "Yes," attach a letter setting forth the circumstances of such action.**

Section B: Pharmacy Licensure Information

Pharmacy permit number _____

Section C: Business Information

1. List the name, address and telephone number of the person who has administrative or managerial responsibility for the registered location.

2. List the name, address and telephone number of the registered agent (if a corporation) or the name and address of the New Jersey resident upon whom process may be served (if a nonresident proprietor or partner).

Section D: Certification

I, _____ being duly sworn, depose and say under penalty of false statement, that I am the person described and identified in this application; that the information given in this application and all 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, my application may be rejected, and I may face legal sanctions if I am already registered. I understand that in signing this application for registration, I am consenting to any reasonable inquiry that may be necessary to verify the information that I have provided on this form or may provide in conjunction with this application.

Applicant's signature

Date

FOR STATE USE ONLY

C.D.S. number_____ Effective date _____ Expiration date _____

Retain a copy for your records. Email or mail completed application as directed on instruction sheet.

New Jersey Office of the Attorney General
Division of Consumer Affairs
Drug Control Unit
124 Halsey Street, 6th Floor, P.O. Box 45045
Newark, NJ 07101
(973) 504-6351

CDS Facility Application Attestation

I, _____ and being duly sworn, depose and say under penalty of false
Your name

statement, that I am an authorized representative of_____ ;
Facility name

that I am the person described and identified in this application; that I have completed this application, which contains all information called for and bears my original signature(s); that the information given in this application and all 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, my application may be rejected, and I may face legal sanctions if I am already registered. I understand that in signing this application for registration, I am consenting to any reasonable inquiry that may be necessary to verify the information that I have provided on this form or may provide in conjunction with this application.

_____ _____
Signature Date