



New Jersey Office of the Attorney General

Drug Control Unit  
P.O. Box 45045  
Newark, NJ 07101



Initial Application for Registration  
for Dispenser/Prescriber  
Mid-Level Practitioner  
New Jersey Controlled Dangerous Substances Act  
N.J.S.A. 24:21-1 et seq.

Please type or print firmly with a ballpoint pen.

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

1. Provide the applicant's name and the place of business (or, if unavailable, the New Jersey residence) to be registered (do not use solely a P.O. box). **Registration will be provided for New Jersey locations only.** If the registration is for a University of Medicine and Dentistry of New Jersey facility, include the department, room number, designation, e.g. M.E.B., M.S.B., etc. The address of record must be your practice location.

_____	_____	_____
Last name	First name	MI
C.D.S. - Responsible Individual		
_____		_____
Department		Room number
_____		
Street address		
_____	New Jersey	_____
City		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/Prescriber (\$20)  
**Make the check or money order payable to: State of New Jersey**

3. Registration requested for:  Schedules II through V  
If registration is being requested for only certain Schedules, please indicate which Schedules:  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) Are there any criminal charges against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction?\*
- Yes  No
- (e) Are you aware of any action now pending against your professional license, or have you been permitted to surrender or otherwise relinquish your professional license to avoid an inquiry or investigation in New Jersey, any other state, the District of Columbia or in any other jurisdiction?\*
- Yes  No

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

**Section B:** Dispenser/Prescriber (check category)

- A.P.N. (Advanced Practice Nurse)  
 C.N.M. (Certified Nurse Midwife)  
 P.A. (Physician Assistant)

**Section C:** Dispenser/Prescriber Identifying Data

1. New Jersey license number \_\_\_\_\_  
(Must have an active/current N.J. license number and C.N.M.'s must include prescriptive authority suffix.)
2. Mid-Level practitioners are required to collaborate with and/or be supervised by physicians, consistent with agreed upon parameters of their respective practices. As concerns the prescribing and/or ordering/dispensing of C.D.S., by affixing my signature below, I affirm that required oversight regarding C.D.S. exists between me and a duly authorized active New Jersey physician licensee. I understand that any C.D.S. ordering/dispensing/prescribing without the required collaborative or supervisory oversight, or engaging in any violation of the statutes or regulations regarding the ordering/dispensing/prescribing of C.D.S. may be deemed professional misconduct or grounds for disciplinary sanction within the meaning of N.J.S.A. 45:1-21.

\_\_\_\_\_  
Applicant's signature

3. \*Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
You **must** disclose your Social Security number for the reasons stated below. Failure to do so may result in a denial of licensure or certification or license or certificate renewal.

\*Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey child support enforcement law, N.J.S.A. 54:50-25 of the New Jersey taxation law and Section 1128 E(b)(2)A of the Social Security Act, the Unit or licensing agency to which this form is submitted is required to obtain your Social Security number. If you do not have a Social Security number, the Unit must ascertain the reason that you do not have one. The Unit is further obligated to provide your Social Security number to the Director of Taxation, the Probation Division or other agency responsible for child support enforcement and the H.I.P. Data Bank when reporting adverse actions.

You are also being asked to consent, on a voluntary basis, to the use of your Social Security number for the additional reasons stated below.

You are notified that under the Federal Privacy Act (5 U.S.C. Section 552a (note (b))), the Unit or licensing agency to which this form is submitted is requesting the voluntary disclosure of your Social Security number. If you give your consent for the use of your Social Security number, it may be used: to verify the identity of an applicant, to aid in the collection of financial obligations due and owing the Unit or any other state agency, and to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure or certification and disciplinary proceedings.

I, \_\_\_\_\_,  Consent  Do Not Consent  
Applicant's signature

to the use of my Social Security number for any of the additional purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

**Section D:** Certification

I, \_\_\_\_\_ in making this application for registration, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny registration or to withhold renewal of or suspend or revoke a registration issued by the Drug Control Unit.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for registration. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Drug Control Unit.

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

\_\_\_\_\_  
Applicant's full signature Date

**FOR STATE USE ONLY**

C.D.S. number \_\_\_\_\_ Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

Retain a copy for your records. Mail the original and one copy with your fee to the above address.