**CertifiCation of the DestruCtion**

***of New Jersey Prescription Blanks (NJPBs)***

Date:

Consistent with the security objectives of the Uniform Prescription Act, all prescribers or healthcare facilities using New Jersey Prescription Blanks (NJPBs) must notify the Division of Consumer Affairs’ Drug Control Unit of the destruction of NJPBs. The person who shall witness the destruction of the prescriber/healthcare facility NJPBs, shall complete this form. **Note:** The person destroying the NJPBs cannot be the same person who witnesses the destruction.

A separate certification form must be used for each unique batch number or unique order month (15 digit ID). A photocopy of the first and last serial numbers for the NJPBs in the batch must be submitted with this certification. Acceptable means of destruction include shredding, burning, pulping, or pulverizing the NJPBs so that every NJPB is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed. Upon destruction, this completed and signed form along with the NJPB copies, must be e-mailed or mailed to the Drug Control Unit at the above address. If mailing in the certification form and documents, please retain a copy of your submission for your records.

**I. Description of the NJPB Destroyed**

Name of prescriber(s) or healthcare facility appearing on the NJPB:

Professional license number(s) or healthcare facility provider number appearing on the NJPB: Street address: City, State, ZIP code: Telephone #: *(include area code)* Fax #: *(include area code)* DEA #: Batch #: Serial #: Start End:

Quantity destroyed: Date of destruction: 15 Digit ID #: Start End:

**II. Reason for Destruction**

Check applicable incident and complete section III. Method of Destruction of this form.

Unused blanks

Board Order

Damaged/Spoiled

Other *(Please attach a detailed description to this form.)*

**III. Method of Destruction**

Pulp

Shred

Incinerate

Pulverize

**IV. Comments**

If you have additional comments, please attach a detailed explanation to this form.

**Witness Certification**

I, *(print name)*, being of full age, certify and say under penalty of false statement, that I am the person described and identified in this certification; that the information given in this certification 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, I and/or the licensee may face legal sanctions. I understand that in signing this certification of destruction, 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 certification.

Name of witness *(print)*

*Title* of witness *(print)*

Signature of witness to destruction of NJPBs

Street address:

City, State, ZIP code:

Send to:

**New Jersey Office of the Attorney General Division of Consumer Affairs**

**Drug Control Unit - NJPB**

**124 Halsey Street, 6th floor, P.O. Box 45045 Newark, New Jersey 07101**

Telephone: 973-504-6200

Fax: 973-504-6326

E-mail: NJPB@dca.lps.state.nj.us

Person destroying NJPBs:

Name: Title: Affiliation:

(Name of prescriber or healthcare facility)

Street address: City: State: ZIP code: Telephone #: Fax #:

*(include area code) (include area code)*

E-mail address: