New Jersey Department of Health
AIDS Drug Distribution Program (ADDP)
PO Box 722
Trenton, NJ 08625-0722

CERTIFICATION BY PHARMACIST

If you need assistance completing this form, call toll free 1-877-613-4533.

SECTION I - TO BE COMPLETED BY APPLICANT

You must make an agreement with a Medicaid/PAAD participating pharmacist to dispense FDA-approved AIDS-related drugs on your behalf. Please complete the requested information in Section I. Forward to your pharmacist for completion of Section II. Ask your pharmacist to return the completed form to you.

Name of Applicant	Social Security Number
Address	Date of Birth
Signature of Applicant	Date

SECTION II - TO BE COMPLETED BY PHARMACIST

The individual named above has applied to the New Jersey Department of Health for participation in the AIDS Drug Distribution Program. Please provide the following information regarding the applicant. Return this completed Certification form to the applicant to submit along with the completed Application.

Name of Pharmacy	Telephone Number
Street Address	
City, State, Zip Code	

CERTIFICATION

I agree to dispense FDA-approved AIDS/HIV-related drugs to the applicant named above and accept reimbursement from the New Jersey Department of Health as payment in full.

Name of Pharmacist (Print)		Telephone Number
Pharmacist License Number	Pharmacy Medicaid/PAAD Provider Number	
Signature of Pharmacist		Date

Applicant: Forward this completed Certification to ADDP, along with your completed Application.