



CLINTON TOWNSHIP POLICE DEPT.

APPLICANT INSTRUCTIONS

- Provide your applicant with your nine digit Originating Agency Identification Number (ORI).

ORI number NJ0100600

- Instruct your applicant to log on to <https://www.njportal.com/njsp/criminalrecords/> and click on the **ON LINE FORM 212A**, a highlighted block located on the lower left side of the page.
- The applicant will follow the prompts for demographic and payment information.
- Upon completion of the form the applicant will receive an email Confirmation & Receipt that will include a confirmation number.
- At this time the request will be forwarded to the Police Department's work queue for approval and submission to the NJ State Police for processing.
- The applicant can find more detailed information by clicking on the **Help Tab**, located on the top right side of the page.



This form is prescribed by the Superintendent for use by applicants for duplicate Firearms I.D. Cards. Any alteration to this form is expressly forbidden.



STATE OF NEW JERSEY

Application for Duplicate Firearms Purchaser Identification Card

All persons wishing to obtain a duplicate Firearms Purchaser Identification Card are required to complete this application form.

- Check Appropriate Block(s)
- | | |
|--|---|
| <input type="checkbox"/> Application to replace lost or stolen Identification Card | <input type="checkbox"/> Application for change of address on Identification Card |
| <input type="checkbox"/> Application to replace mutilated Identification Card | <input type="checkbox"/> Application for change of sex on Identification Card |
| <input type="checkbox"/> Application for change of name on Identification Card | |

List former name here and attach copy of marriage license or court order _____

(1) Last Name (If female, include maiden) First			Middle	(2) Resident Address (Number - Street - City - State - Zip)				
(3) Date of Birth Month / Day / Year	(4) Age	(5) Distinguishing Physical Characteristics (Marks, Scars, Tattoos)			(6) U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	(7) Social Security Number - - -		
(8) Sex	Height	Weight	Eyes	Race	Hair	Complexion	(9) Driver's License Number & State	(10) Home Telephone () -
(11) Address Appearing on Former Card								(12) N.J. Firearms ID Card/ SBI number
(13) Have you ever been adjudged a juvenile delinquent?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, List Date(s)		Place(s)	Offense(s)		
(14) Have you ever been convicted of a disorderly persons offense, that has not been expunged or sealed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, List Date(s)		Place(s)	Offense(s)		
(15) Have you ever been convicted of a criminal offense, that has not been expunged or sealed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, List Date(s)		Place(s)	Offense(s)		
(16) Have you ever had a firearms purchaser identification card, permit to purchase a handgun, or permit to carry a handgun refused or revoked?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, By Whom?		When?	Where	Why?	
(17) Have you ever had an Employee of Firearms Dealer License refused or revoked?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, By Whom?		When?	Where	Why?	
(18) Are you an Alcoholic?		<input type="checkbox"/> Yes <input type="checkbox"/> No	(19) Have you ever been confined or committed to a mental institution or hospital for treatment or observation of a mental or psychiatric condition on a temporary, interim or permanent basis? If Yes, give the name and location of the institution or hospital and the date(s) of such confinement or commitment.					<input type="checkbox"/> Yes <input type="checkbox"/> No
(20) Are you dependent upon the use of any narcotic or other controlled dangerous substance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	(22) Have you ever been attended, treated or observed by any doctor or psychiatrist or at any hospital or mental institution on an inpatient or outpatient basis for any mental or psychiatric conditions? If Yes, give the name & location of the doctor, psychiatrist, hospital or institution and the date(s) of such occurrence.					<input type="checkbox"/> Yes <input type="checkbox"/> No
(21) Are you now being treated for a drug abuse problem?		<input type="checkbox"/> Yes <input type="checkbox"/> No						
(23) Do you suffer from a physical defect or sickness?		<input type="checkbox"/> Yes <input type="checkbox"/> No						
(24) If answer to question 23 is yes, does this make it unsafe for you to handle firearms? If not, explain.			<input type="checkbox"/> Yes <input type="checkbox"/> No	(25) Are you subject to any court order issued pursuant to Domestic Violence? If yes, explain.			<input type="checkbox"/> Yes <input type="checkbox"/> No	
(26) Have you ever been convicted of any domestic violence in any jurisdiction which involved the elements of (1) striking, kicking, shoving, or (2) purposely or attempting to or knowingly or recklessly causing bodily injury, or (3) negligently causing bodily injury to another with a weapon? If Yes, explain.								<input type="checkbox"/> Yes <input type="checkbox"/> No
(27) Are you presently, or have you ever been a member of any organization which advocates or approves the commission of acts of violence, either to overthrow the government of the United States or of this State, or to deny others of their rights under the Constitution of either the United States or the State of New Jersey? If yes, list name and address of organization(s) here:								<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT: DO NOT WRITE BELOW THIS SPACE

A Request for a Criminal History Name Check (SBI 212A) must accompany this application along with the required fee payable to "Division of State Police SBI." Application must be made to the Chief of Police, in the municipality in which you reside or to the Superintendent in all other cases.

APPROVED

IDENTIFICATION CARD NUMBER

DISAPPROVED

Reason for Disapproval

- ☐ A. CRIMINAL RECORD
☐ B. PUBLIC HEALTH SAFETY AND WELFARE
☐ C. MEDICAL, MENTAL OR ALCOHOLIC BACKGROUND
☐ D. NARCOTICS/ DANGEROUS DRUG OFFENSE
☐ E. FALSIFICATION OF APPLICATION
☐ F. DOMESTIC VIOLENCE
☐ G. OTHER (SPECIFY) _____

GRANTED ON APPEAL

I hereby certify that the answers given on this application are complete, true and correct in every particular. I realize that if any of the foregoing answers made by me are false, I am subject to punishment.

(28)

Signature of Applicant

Date of Application

(The disclosure of my social security number is voluntary. Without this number, the processing of my application may be delayed. This number is considered confidential.)

Falsification of this form is a crime of the third degree as provided in NJS 2C:39-10c.

APPLICANT: DO NOT WRITE BELOW THIS SPACE

This _____ Day of _____, 20____

Signature

Title



CONSENT FOR MENTAL HEALTH RECORDS SEARCH

This consent **MUST** be completed by the firearm applicant.
Failure to consent requires denial or disapproval of the application.



N.J.S.A. 30:4-24.3 provides that all records of any individual's commitment to a non-correctional institution for mental health reasons shall be confidential and shall not be disclosed except in limited circumstances or with the consent of the individual.

PART ONE (To be completed by the applicant)

Name: (Last, Maiden, First, MI)		Date of Birth: (Month, Day, Year)		Social Security Number:	
Address: (Number & Street)		(Municipality)	(County)	(State)	

List Prior Addresses for past 10 years: ☐ NOT APPLICABLE

ADDRESS 1: Dates Resided From: _____ To: _____			
(Number & Street)	(Municipality)	(County)	(State)

ADDRESS 2: Dates Resided From: _____ To: _____			
(Number & Street)	(Municipality)	(County)	(State)

I, _____ am aware of my rights under N.J.S.A. 30:4-24.3, and the Health Insurance Portability and Insurance Accountability Act (HIPAA), 45 C.F.R. 164.50, and consent to the disclosure of my mental health records to the Chief of Police and the Superintendent of State Police, or their designees, for the purpose of verifying my firearms permit application and my fitness to own a firearm under N.J.S.A. 2C:58-3. I understand that copies of this authorization shall be considered sufficient authorization for the release of records.

Investigating Police Department _____

Witness (Print Name) _____

X

Signature of Witness _____

X

Signature of Applicant _____

Date _____

The disclosure of my Social Security Number is voluntary. Without this number, the processing of my application may be delayed. This number is considered confidential.

PART TWO (To be completed by County Adjuster's Office, Mental Health Institution and/or Doctor)

	Record of Admission Commitment or Treatment	Date of Check	Signature of Authorized Official or Doctor (Dr.: Provide Medical License #)
County Adjuster's Office	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Expunged	_____	_____
Institution or Doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Expunged	_____	_____

PART THREE (To be completed by authorized official or doctor only if applicant has record of admission, commitment, or treatment at a hospital, mental institution or sanitarium for a mental disorder)

NAME OF HOSPITAL, MENTAL INSTITUTION OR SANITARIUM	ADMISSION (mo/day/yr)	DISCHARGE (mo/day/yr)	SIGNATURE OF AUTHORIZED OFFICIAL OR DOCTOR
_____	_____ to _____	_____	_____
_____	_____ to _____	_____	_____