



Donna A. Higbee
Chief of Police

TOWNSHIP OF GALLOWAY
POLICE DEPARTMENT



300 E. JIMMIE LEEDS ROAD, GALLOWAY, N.J. 08205
(609) 652-3705 FAX: (609) 652-5710

FIREARMS APPLICATIONS

Firearms Application & Registration System (FARS) Procedure for Applicants:

1. Visit this website. You **MUST** enter the site address as follows:
www.njportal.com/NJSP/fars

****Please note this site / portal is not administered by the
Galloway Township Police Department****

2. The Galloway Township Police Department ORI # is **NJ0011100**. (You will **NOT** be able to complete the FARS Online application **WITHOUT THIS ORI#**)
3. Complete the online application. You may complete by using a smartphone, mobile device, laptop or desktop computer. When completing the application, you will need the email addresses of two (2) reputable references.
4. You **MUST** appear at the Galloway Police Department to pay for your Initial FID and / or Pistol Permit(s). Initial FID card fee is \$5.00 and Pistol Permit fee is \$2.00 each and payable **ONLY** in the form of a check or money order to Galloway Township Police Department. **Non-refundable payment** is required to be made prior to the completion of the background as per NJAC

13:54-1.4. You **MUST** also complete and sign the Consent for Mental Health Records form.

****Print a copy of the application and the confirmation page and bring in with you**.**

You will be receiving automated email updates throughout this new process.

Once your application is complete, a Galloway representative will contact you to retrieve your FID card and / or permit documents.

Please advise your references that the FARS system will email them the questions to be answered. Your references can complete the questions using a smartphone, mobile device, laptop or desktop computer. Please advise them to complete the questions immediately to progress your background investigation.

The online application is **APPLICANT DRIVEN**. Please ensure that you have entered the best phone numbers and email address for yourself and references.

Check List:

You will be dropping off:

Check or money order payable to Galloway Township Police Dept.
Consent for Mental Health Records Form.

Copy of your application and the confirmation page.



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 #:** *See Privacy Act Notice Below. _____

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, including disclosure of the fact that said records may have been expunged, 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 or for the disclosure of the fact of expungement.

Investigating Police Department

Witness (Print Name)

X _____
Signature of Witness

X _____
Signature of Applicant

Date

* Applicant's Social Security Number is requested pursuant to N.J.S.A. 2C:58-3(e) and disclosure is voluntary. The number will be used to expedite the application. Without this number, the processing of the 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 <small>(Dr.: Provide Medical License #)</small>
_____ 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 _____	_____

*Additional forms may be obtained through the New Jersey State Police, Firearms Investigation Unit,
P.O. Box 7068, West Trenton, NJ 08628-0068, or via the internet at www.njsp.org/info/forms.html.*