

# Rhode Island Department of Health

## Application and Instructions for:



Manager Certified In Food Safety (State/Municipal)

[Redacted area for Applicant Name]

Applicant Name

OFFICE USE ONLY

	Initials	Date
Approved by F.O. Supervisor		
Profile Entered By		
License ID#		
Receipt No.		
License No.		

# INSTRUCTIONS

- Registration shall be based upon **Satisfactory Compliance** with all applicable laws and regulations.
- Registration forms must be either typed or legibly printed using a ball point pen, except signatures, which must be written in ink. Please answer all questions. Do not leave blanks. Incomplete applications will be returned to you and your license/permit will not be issued.
- Attach check/money order to the front of this application and mail or hand-deliver to: Center for Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097. A receipt or canceled check does not guarantee licensure.

## Application Fees:

**Food Safety Manager                      \$50.00**

- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash. **This fee is non-refundable.**
- If you have any questions concerning this application, call the Department of Health, Center for Food Protection at (401) 222-2749.

**NOTE:** If you are **not** a State or Municipal Employee, this is the **WRONG** application. Please contact the Center for Food Protection at the above number for the correct application.

**NOTE:** Please notify the Center for Food Protection in writing within ten (10) days of a change of name, employment or address.

## **REQUIRED ATTACHMENTS:**

**Enclose a copy of your birth certificate or proof of lawful entry to the country or a copy of your driver's license.**

**Attach a copy of your Food Safety Certificate along with hours of training.**

**If you are enclosing a birth certificate, please attach a recent identification photograph in the space provided below:**

Attach Photo Here
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# State of Rhode Island and Providence Plantations

## Department of Health Center for Food Protection

**Name:**

This is the name that will be printed on your License and reported to those that inquire about your License.

Do not use nicknames, etc.

Name: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

**Social Security Number:**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**Gender:** M F**Date and Place of Birth:**

Date

\_\_\_\_/\_\_\_\_/\_\_\_\_

Place

\_\_\_\_

City

State

**Residence Information:**

It is your responsibility to keep the Department apprised of all address and phone number changes.

**(Not published on the HEALTH web site).**

Address Line1 \_\_\_\_\_

Address Line2 \_\_\_\_\_

Address Line3 \_\_\_\_\_

City, State, ZipCode \_\_\_\_\_

Country (only if not in US) \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Business/Employment Information:**

Please provide the employment information related to this license. Include Name of Business/Employer (ie. Memorial Hospital)

**(Published on the HEALTH web site).**

Facility Name \_\_\_\_\_

Facility License Number \_\_\_\_\_

Address Line1 \_\_\_\_\_

Address Line2 \_\_\_\_\_

Address Line3 \_\_\_\_\_

City, State, ZipCode \_\_\_\_\_

Country (only if not in US) \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Business/Employer License Number:

**MANDATORY**

Please provide the RI Department of Health License Number of the Business where you will be working.

(FSV/MRK) \_\_\_\_\_

<p><b>Education Information:</b></p> <p><b>NOTE: You must enclose a copy of course completion certificate or RECIPROCITY APPLICANTS enclose equivalent educational credentials or certification credentials from participating agency.</b></p>	<p>Did you complete a fifteen (15) hour Division approved Food Safety Training Course?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <hr/> <p>Did you pass the Food Protection Certification Monitored Examination?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>If Yes,</p> <p>Course Location <input type="text"/> Instructor License # <input type="text"/></p> <p>Name of Testing Company <input type="text"/></p> <p>Date of Examination <input type="text"/> Certificate No. <input type="text"/></p>
<p><b>Social Security Number (SSN)</b></p>	<p>Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.</p> <p><b>SSN#:</b> <input type="text"/></p>
<p><b>Affidavit of Applicant</b></p> <p>Read, sign and date this Affidavit.</p>	<p style="text-align: center;"><b>AFFIDAVIT AND SIGNATURE</b></p> <p style="text-align: center;"><b>This Application Must be Signed</b></p> <p><b>I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my License in the State of Rhode Island.</b></p> <p><b>I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.</b></p> <p><b>Signature of Applicant</b> <input type="text"/></p> <p style="text-align: right;"><b>Date of Signature (MM/DD/YY)</b> <input type="text"/></p>