Revised 06/09/2015

Rhode Island Department of Health

Application and Instructions for:

Resort, Lodging, Camp - Non Profit

Name of Business

Previous Business Name & License Number (If Any) at this address

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.

- **Upon receipt of your completed application by the Department of Health, Office of Food Protection, please call (401) 222-2749 to schedule an operational inspection 2 weeks prior to opening**. **Note: You must have or employ an active Certified in Food Safety Manager registered with the Office of Food Protection (if applicable) prior to inspection.**

- If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.

- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

Please complete the section(s) below.

Food Service:	☐ Food Service Available – (***See Below)** ☐ Food Service Not Available *Note – If food is being served at this location, you must also possess a valid, active Food Service (FSV) license to operate.

State of Rhode Island and Providence Plantations
Department of Health
Office of Food Protection

Facility Name: Please provide the name of the facility (as known to the public) for which you are applying for this license.	Name:
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: Phone Number: ( )
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website).**	Address Line 1 Address Line 2 Address Line 3 City,State, ZipCode Country (only if not in US) Phone: Fax: Email Address:
Facility Location Information: Please provide the location information for this facility. (P**ublished on HEALTH website)**	Address Line 1 Address Line 2 Address Line 3 City,State, ZipCode Country (only if not in US) Phone: Fax: Email Address:
Ownership Type: Please check ONE:	☐ Corporation ☐ Limited Liability Company ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Partner

Ownership Information: Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	**LIST ONE ONLY - DO NOT SEND ATTACHMENTS** Name: DBA (Doing Business As):
Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 Address Line 2 Address Line 3 City, State, Zipcode Phone: Fax: Email Address:
Water Supply:	Does this establishment receive all or a portion of its water supply from an on-site well? ☐ Yes ☐ No
Sewage System:	Is this establishment serviced by a private sewage system (e.g. septic system)? ☐ Yes ☐ No
Campground Housing Units and Camp Sites:	Please indicate the number of housing units. Please indicate the number of camp sites.
Person Capacity:	What is the daily person capacity for the facility?
Swimming:	Please indicate swimming availability below: ☐ Pool ☐ Stream ☐ Ocean ☐ Pond ☐ No Swimming Available
Seasonal Operational Dates:	If this is a seasonal operation, please indicate dates below: Open on: month/day/year Close on: month/day/year
SSN/FEIN: **(Social Security Number/Federal Employer Identification Number)** **Please note if you are a sole proprietor this number may be your SSN.**	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. SSN/FEIN #:

Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **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 this License in the State of Rhode Island.** **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.** **Signature of Authorized Person** — **Date of Signature (MM/DD/YY)** **Printed Name of Authorized Person** **Title of Authorized Person**