

RI Department of Health

Application and Instructions for:



Market Cash Registers 1-2

Market Cash Registers 3-5

Market Cash Registers 6 or More

Applicant Name (Name of Business)

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

OFFICE USE ONLY

	Initials	Date
Risk Type		
Approved by F.O. Supervisor		
Profile Entered By		
License ID#		
Receipt No.		
License No.		
Certified Food Safety Manager Required: 0 ___ 1 ___ > 1 ___		

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 to: Office of Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097. A receipt or cancelled check does not guarantee licensure.

Application Fees:

Market Cash Register 1-2	\$120.00
Market Cash Register 3-5	\$240.00
Market Cash Register 6 or More	\$510.00

- 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 on, 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.

Note to Applicants submitting plans:

Plan Review

RIGL 23-1-31. Approval of construction by director. – A plan review fee for new establishments, and for establishments where the cost of renovation exceeds 50 percent (50%) of the value of the establishment, shall be charged. The plan review fee for these establishments shall equal the annual cost of the license/registration.

A plan review fee of \$_____ is included with this application.

I have enclosed a separate check/money order payable to "General Treasurer, State of Rhode Island".

Please check and indicate the type of operation by choosing **one** only.

Convenience Store

Department Store

Farm Stand

Liquor Store

Meat Market

Pharmacy

Seafood Market

Super Market

Other (describe) _____



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, Zip Code _____

Country (only if not in US) _____

Phone: _____

Fax: _____

Email Address: _____

Facility Location Information:

Please provide the location information for this facility.

(Published on HEALTH website)

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

City, State, Zip Code _____

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): _____

<p>Ownership Address Information:</p> <p>Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>City, State, Zip Code _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p>Water Supply:</p>	<p>Does this establishment receive all or a portion of its water supply from an on-site well?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Sewage System:</p>	<p>Is this establishment serviced by a private sewage system (e.g. septic system)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Employees:</p> <p>Please indicate the number and types of employees.</p>	<p>Number of food handling employees: _____</p> <p>Number of non-food handling employees: _____</p>
<p><u>Certified Food Safety Manager(s) is required if potentially hazardous foods are prepared.</u></p> <p>If you need additional space, please submit under separate cover.</p>	<p>Does this facility have a certified food safety manager? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please indicate name and license number below of primary food safety manager:</p> <p>Name: _____</p> <p>FMC #: _____</p>
<p>Chain Information:</p>	<p>Is this facility part of a chain operation?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Menu:</p>	<p>Please attach a copy of a complete menu from your establishment.</p>
<p>Affidavit of Applicant</p> <p>Read, sign, and date this affidavit.</p>	<p style="text-align: center;">AFFIDAVIT AND SIGNATURE</p> <p style="text-align: center;">This Application Must be Signed</p> <p>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.</p> <p>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.</p> <p>_____</p> <p>Signature of Authorized Person</p> <p>_____</p> <p>Printed Name of Authorized Person</p> <p>_____</p> <p>Title of Authorized Person</p> <p>_____</p> <p>Date of Signature (MM/DD/YY)</p>

