



RHODE ISLAND DEPARTMENT OF HEALTH
DIVISION OF FOOD PROTECTION

Three Capitol Hill, Room 203
Providence, RI 02908-5097
Phone: (401) 222-2750, Fax (401) 222- 4775

PURPOSE OF APPLICATION		
<input type="checkbox"/> Construct	<input type="checkbox"/> Alter	<input type="checkbox"/> Addition
(Check) <input type="checkbox"/> Independent	<input type="checkbox"/> Chain	

APPLICATION FOR CONSTRUCTION

Business Location

Street Address or Pole Number

City/Town

Zip Code

NAME OF BUSINESS

Phone Number

List name of individual or corporation, title, residence, address and phone of each owner, principal, partner, corporate officer.

OWNER(s)

- 1)
- 2)
- 3)

Phone:
Phone:
Phone:

BUILDING USE

Describe the operation(s)

CAPACITY:

Sites _____ Seats _____ Persons _____

Estimated Food Handling Employees _____

WATER SYSTEM:

PUBLIC PRIVATE (If private, describe)

SEWAGE SYSTEM:

PUBLIC PRIVATE (If private, describe)

- A) Have plans and application to construct a new sewage system been filed? Yes No
- B) Has system been approved by the Department of Environmental Management? Yes No

PLANS AND SPECIFICATIONS REQUIRED: THREE (3) COPIES OF PLANS AND SPECIFICATIONS FOR THE PROPOSED CONSTRUCTION, ADDITION OR ALTERATION MUST ACCOMPANY APPLICATION.
(SEE SEPARATE INSTRUCTION SHEET FOR DETAILS)

The Owner certifies that the information hereon is true and correct, that it complies with the rules and regulations of the Rhode Island Department of Health now in effect, and that the information and all forms, submittals, plans, and sketches which are enclosed herewith is true and correct, and that both accurately and truthfully represent that which is to be constructed on the site, and further certifies that the business will be in strict accordance with this application and attached forms, of the representations heron, and on all forms, submittals, plans and sketches attached hereto, and assume all liability and responsibility, and agrees to hold the Department of Health harmless from any and all claims against such future failure.

SIGNATURE OF OWNER _____

DATE

DISPOSITION OF APPLICATION (Health Department Only)

This application, plans, specifications and other related data are hereby:

APPROVED:

Based upon the representation of the Owner, and Owner's agents and/or servants, including the representation of the Owner's architect and/or builder, regarding the truth and accuracy of all information submitted on the application and the accompanying forms, submittals, plans and sketches, this application for constructing, altering or adding to a Facility is hereby approved. The Department of Health assumes no responsibility or liability for the future safe operation or maintenance of the aforesaid business, nor does it assume any responsibility for the accuracy and truth of the Owner's agents' and/or servants' representations. This approval is subject to future suspension and revocation in the event that subsequent examination reveals any of the data indicated on any application, form, plan or sketch to be incorrect, or not in compliance with applicable laws and regulations. It **does NOT** indicate compliance with any other code, law or regulations that may be required -- Federal, State or Local.

DISAPPROVED:

SIGNATURE OF HEALTH DEPARTMENT AUTHORITY

DATE

OFFICE

*****NOTE: PLAN REVIEW FEE IS NON-REFUNDABLE*****