Revised 06/08/2015

Rhode Island Department of Health

Application and Instructions for Food Business:

☐ Market Cash Registers 1-2

☐ Market Cash Registers 3-5

☐ Market Cash Registers 6 or More

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.

- **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.**

Initial registration fee is prorated based on the date of application registration (check ONE below), automatic renewal payment due on following September 30 cycle at 100%.

Licensing Cycle Expiration Date 9/30	August 1-December 31 (100%)	January 1 -March 31 (75%)	April 1 -July 31 (50%)
Market Cash Registers 1-2	$120.00 ☐	$90.00 ☐	$60.00 ☐
Market Cash Registers 3-5	$240.00 ☐	$180.00 ☐	$120.00 ☐
Market Cash Registers 6 or More	$510.00 ☐	$385.00 ☐	$255.00 ☐

- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash. **Fees are 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 section(s) below.

Note to Applicants submitting plans:

Plan Review

One time plan review fee is not prorated

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.
Plan review fee Market Cash Registers 1-2…..$120.00
Plan review fee Market Cash Registers 3-5…. $240.00
Plan review fee Market Cash Registers 6 or More…. $510.00
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
- ☐ Farm Stand
- ☐ Meat Market
- ☐ Seafood Market
- ☐ Other (describe)
- ☐ Department Store
- ☐ Liquor Store
- ☐ Pharmacy
- ☐ Super Market

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 ☐ Governmental Entity ☐ Partnership ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Limited Partnership

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, Zip Code 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
Employees: **Please indicate the number and types of employees.**	Number of food handling employees: Number of non-food handling employees:
<u>Certified Food Safety Manager(s) is required if potentially hazardous foods are prepared.</u> If you need additional space, please submit under separate cover.	Does this facility have a certified food safety manager? ☐ Yes ☐ No If yes, please indicate name and license number below of primary food safety manager: Name: FMC #:
Chain Information:	Is this facility part of a chain operation? ☐ Yes ■ No
Menu:	Please attach a copy of a complete menu from your establishment.
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** **This Application Must be Signed** **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**