Revised 08/19/2020

Rhode Island Department of Health

Application and Instructions for:

Manager Certified In Food Safety

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 ballpoint 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 cancelled 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 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:

Please 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

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 Line 1 Address Line 2 Address Line 3 City,State, ZipCode Country (only if not in US) Phone: Fax: Email Address:
Business/Employment Information: Please provide the employment information related to <u>this</u> license. Include Name of Business/Employer (ie. Memorial Hospital) (**Published on the HEALTH web site**).	Facility Name Address Line 1 Address Line 2 Address Line 3 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) ______________________________

Education Information: **NOTE: You must enclose a copy of course completion certificate or RECIPROCITY APPLICANTS enclose equivalent educational credentials or certification credentials from participating agency.**	Did you complete an eight (8) hour Division approved Food Safety Training Course? Yes No Did you pass the Food Protection Certification Monitored Examination? Yes No If Yes, Course Location Instructor License # Name of Testing Company Date of Examination Certificate No.
Social Security Number (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 #:**
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 my 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 Applicant** **Date of Signature (MM/DD/YY)**